

Diagnostics and Therapeutics for Arterial Wall Disruptive Disorders

Field of Invention

The invention relates to diagnostics, therapeutics and animal models for arterial wall disruptive disorders, including arterial aneurysmal disease.

Background of the Invention

Disorders of the peripheral arterial system cause their pathological effects by two general mechanisms: obstruction of the arterial lumen or disruption of the vessel wall. Arterial obstruction most commonly results from atherosclerosis, although other causes of luminal blockage may be identified, including inflammatory conditions, external compression, emboli, thrombi or fibromuscular dysplasia. Arterial obstructive disorders typically affect multiple sites within the arterial tree. Disruption of the arterial wall results in aneurysm formation, arterial wall dissection or frank arterial rupture. Arterial aneurysm formation is most commonly related to atherosclerosis. Aneurysms may also result from infections, cystic medial necrosis, congenital anomalies or trauma. As used herein, trauma shall include both non-iatrogenic and iatrogenic processes. Arterial wall dissection may arise as a complication of an aneurysm or as an independent event. Arterial wall dissection in the absence of a pre-existing aneurysm may occur spontaneously, or it may result from trauma. Frank arterial rupture may result from the progressive expansion of an arterial aneurysm beyond a certain critical diameter. If no aneurysm is present, the most common cause of arterial rupture is some type of arterial trauma. Artery wall disruption may affect multiple sites, or may be localized to only one location.

Aneurysmal disorders or aneurysmal diseases, as these terms are used herein, include those processes that result in aneurysm formation in a segment of at least one artery. An aneurysm is understood to be a permanent localized dilatation of an artery with increase in diameter of 1.5 times normal, recognizing that values for normal arterial diameter vary with age, sex and blood pressure. (Vermilion BD et al., "A review of one hundred forty-seven popliteal aneurysms with long-term follow-up," Surgery 90:1009, 1981). Aneurysms cause symptoms by rupturing, by compressing adjacent structures, by leaking, by obstructing flow to vessels that arise from the segment of artery affected by the aneurysm, and by accumulating thrombus within the vessel lumen at the site of the aneurysm, said thrombus being capable of suddenly occluding

smaller
the vessel or of sending smaller emboli into the distal arterial tree.

Aneurysms may be classified according to the anatomic site where they arise. Common types of aneurysms include aortic aneurysms, peripheral aneurysms, visceral aneurysms and intracranial aneurysms. The most common location for an arterial aneurysm is the infrarenal aorta. Aneurysms of the infrarenal aorta, also referred to as abdominal aortic aneurysms or "AAAs," occur three to seven times more frequently than thoracic aneurysms. Aneurysms at other anatomic locations are frequently found in patients with AAAs, locations including the common or internal iliac artery and the femoral-popliteal arterial system. (Goldstone J, "Aneurysms of the aorta and iliac arteries," pp. 435-455 in WS Moore, Vascular Surgery: A Comprehensive Review, WB Saunders, 1998, the teachings of which are incorporated herein by reference). So-called peripheral aneurysms involve those arteries of the upper extremities distal to and including the subclavian artery, those arteries of the lower extremities distal to and including the femoral artery, and the extracranial carotid arteries. Peripheral aneurysms are rare as compared to aortic aneurysms. Unlike AAAs, which tend to rupture, peripheral aneurysms tend to thrombose or give rise to arterial aneurysms. (Flanigan D, "Aneurysms of the peripheral arteries," pp. 457-467 in WS Moore, Vascular Surgery: A Comprehensive Review, WB Saunders, 1998, the teachings of which are incorporated herein by reference). Unlike AAAs, where size is a main determinant of the need for surgery, peripheral aneurysms tend to be corrected surgically as soon as they are identified. Visceral aneurysms involve the major branches of the abdominal aorta. (Stanley JC et al., "Splanchnic and renal artery aneurysms," pp. 468-481 in WS Moore, Vascular Surgery: A Comprehensive Review, WB Saunders, 1998, the teachings of which are incorporated herein by reference). These rare types of aneurysms arise from the splanchnic vessels and the renal arteries. About one fourth of splanchnic artery aneurysms present as acute surgical emergencies, with a high rate of mortality. Intracranial aneurysms are typically congenital in origin, evolving and expanding during life. (Hoff JT et al., "Neurosurgery," pp. 1877-1908 in Schwartz, S. I. (Ed.), Principles of Surgery, 7th edition, McGraw-Hill, NY, 1999, the teachings of which are incorporated herein by reference). Typically they are found at the bifurcations of the major vessels of the arterial Circle of Willis. Up to 20% of patients with intracranial aneurysms have multiple aneurysms. The most common presentation for an intracranial aneurysm is subarachnoid hemorrhage, with varying degrees of severity that can extend to permanent neurological deficit, coma and death. (Easton JD et al., "Cerebrovascular diseases," pp. 2325-2348, in Harrison's, the teachings of which are incorporated herein by reference).

Remarkably, aneurysms may remain asymptomatic for prolonged periods of time. In the

example,

5 infrarenal aorta, for example, 70 to 75% of all aneurysms are asymptomatic when first discovered. Most commonly, they are discovered during a routine physical examination or during a radiographic study undertaken to diagnose an unrelated condition (e.g., an upper GI series, a barium enema, an intravenous pyelogram, an abdominal ultrasound, an abdominal CT scan, or a series of lumbosacral spine Xrays). 43% of patients with non-dissecting thoracoabdominal aortic aneurysms (TAAAs) are asymptomatic at the time of diagnosis. (Hamilton I, et al., "Thoracoabdominal aortic aneurysms," pp. 417-433 in in WS Moore, Vascular Surgery: A Comprehensive Review, WB Saunders, 1998, the teachings of which are incorporated herein by reference). If an aneurysm is asymptomatic, it may go undetected until it ruptures.

10 For certain etiologies of aneurysms, other non-vascular symptoms or signs may raise the clinician's suspicion that an aneurysm may be present. For aneurysms caused by infectious agents, termed mycotic aneurysms, a febrile illness followed by persistent fever and leukocytosis may alert the physician to the presence of a mycotic aneurysm. No screening tests apart from medical history and physical examination exist for identifying asymptomatic aneurysms. (Pleumeekers HJ, et al., "Selecting subjects for ultrasonographic screening for aneurysms of the aortic aorta: four different strategies", Int J Epidemiol, 28(4):682-6 1999 Aug.) Physical examination is further limited to those areas accessible to palpation. Thus, while many peripheral aneurysms and some aortic aneurysms can be identified by physical examination, visceral and intracranial aneurysms cannot.

15 In certain patients, the first symptom of the aneurysm is rupture. For example, the presence of a AAA is known prior to rupture only in about 25-33% of patients presenting with symptoms of rupture. Rupture of a AAA is a catastrophic event accompanied by a mortality rate approaching 90%. Repair of the ruptured aneurysm is likewise accompanied by an extremely high mortality. Of those patients who reach the hospital with a ruptured AAA, for example, only about half survive. Ruptures of aneurysms in other anatomic locations are accompanied by formidable rates of morbidity and mortality. For example, in patients with TAAAs that rupture, the majority of patients will die outside the hospital. There remains a need in the surgical art to identify those asymptomatic patients at risk for aneurysm development so that they can be evaluated for occult aneurysms before they rupture. Diagnostic methods applicable to aneurysms include radiological techniques like MRI, CT scan, angiography and ultrasound, as well as anatomically targeted techniques like transesophageal echocardiography. None of these methods, though, are applicable for screening a large population of asymptomatic patients.

30 If an asymptomatic aneurysm is identified at an early stage, surgery may be

certain cases,

monitored

recommended. In ~~certain~~ *certain cases,* however, the aneurysm may be ~~monitored~~ *monitored* for expansion over time, with surgery elected when the aneurysm reaches a certain size. Most aneurysms continue to expand over time. They do not contract or regress spontaneously. No method exists for monitoring the expansion of an aneurysm apart from those techniques already described that permit its initial diagnosis. Furthermore, as an asymptomatic aneurysm expands, it may nonetheless remain asymptomatic. Sudden expansion tends to be accompanied by dramatic symptoms, including severe local and radiating pain, while gradual aneurysmal dilatation may remain asymptomatic. The lack of symptoms in a gradually expanding aneurysm may be deceiving, however. It is understood that as an aneurysm expands, it becomes more likely to rupture. The relationship between aneurysmal size and rupture probability is well-established. For example, the five year rupture rate for diagnosed AAA's increases from 25% for a 5 cm. diameter aneurysm to 95% for an aneurysm greater than 7 cm. in diameter. (Szigalyi DE et al., "Clinical fate of the patient with the asymptomatic abdominal aortic aneurysm and unfit surgical treatment," Arch. Surg. 104:600-606, 1972). Smaller diameter aneurysms can and do rupture, however. Autopsy studies have shown that 10% of AAAs less than 4 cm. will rupture, and 23% of AAAs less than 5 cm will rupture. (Darling RC et al., "Autopsy study of unoperated aortic aneurysms," Circ 56 (suppl. 2):161-164, 1977).

In part, the correlation of aneurysm diameter and rupture rate can be explained by the mechanics of the arterial wall. Rupture occurs when the tangential stress on the arterial wall becomes greater than the wall's tensile strength. Tangential stress within the wall of a fluid-filled cylindrical tube is understood to be directly proportional to pressure and radius and inversely proportional to wall thickness. As the vessel expands to form an aneurysm, its radius increases and its wall thickness decreases. For example, while a normal aorta may have a diameter of 2 cm. with a wall thickness of 0.2 cm, an aneurysmal aorta may have a diameter of 6 cm. and a wall thickness of 0.06 cm. If blood pressure remains constant, the diameter is increased by a factor of 3 and the wall stress has increased by a factor of 12. Hence, the larger an aneurysm grows, the more likely it is to rupture. Recognizing this, it would be useful to be able to monitor the aneurysm's expansion non-invasively and frequently to identify when a critical diameter requiring surgery has been reached. It is further understood that the expansion process is accompanied by changes in the arterial wall indicative of alterations in structural integrity and indicative of alterations in local tissue biology. It would therefore be desirable to identify biological markers that relate to these alterations in biochemistry or physiology of the tissues making up the arterial wall wherein those markers further relate to the wall's tendency to develop an aneurysm or to expand an existing aneurysm.

aneurysm

Depending upon

5 Treatment of an aneurysm at present is surgical. Depending on the anatomic location, aneurysmal clipping, aneurysm excision, intraluminal stenting or grafting, or vascular bypass may be indicated. Open techniques may be employed or endovascular techniques may be appropriate, depending upon the location of the aneurysm and its characteristics. The more anatomically extensive the aneurysm, the more extensive is the surgery that is required. With expansion, aneurysms may extend to involve arteries that branch off from the main vessel. Repair of the extensive aneurysm, therefore, may require the reconstruction of branching vessels, adding additional complexity to the procedure. It would be advantageous to identify an aneurysm when its size is smaller, so there would be less likelihood of compromise for branching vessels.

10 In addition, smaller sized aneurysms may be more amenable for endovascular repair, sparing the patient the surgical stress of an open operative technique. Furthermore, certain aneurysms may demonstrate an inflammatory component that can affect adjacent structures. 5% to 10% of AAAs, for example, are associated with this inflammatory reaction that can extend into the retroperitoneum to involve other retroperitoneal structures. It would be advantageous to identify those inflammatory aneurysms at an early stage, before the inflammatory processes have affected the other tissues in the area, increasing the difficulty of the surgical procedure.

15 With a set of disorders as dangerous as arterial wall disruptions, it is understandable that surgery is commonly recommended upon diagnosis. Lacking the ability to identify these disorders at an early stage, when the probability of catastrophic outcome is more remote, clinicians are likely to be disinclined to treat these disorders conservatively or to embark upon medical management, even if such therapies were available. A precondition for the development of medical therapies for aneurysmal disease may be the ability to identify these abnormalities when they are small and thus less likely to rupture. Further, since the progress of the aneurysm cannot be monitored non-invasively, a clinician electing medical management would not be able to determine easily and safely whether the treatment was working. A second precondition for the development of medical therapies for aneurysmal disease may be a non-invasive method for tracking the development of the aneurysm over time, so that medical therapies can be adjusted or replaced with surgery, depending upon the response of the lesion to the treatment. Although great progress has been made in understanding the pathogenesis of aneurysmal disorders, there remains a need in the art for methods that permit early diagnosis and non-invasive monitoring of aneurysmal disorders and arterial wall disruptions. In addition, it would be desirable to produce animal models exhibiting arterial wall disruptions wherein the arterial wall disruptive disorder results from systemic abnormalities similar to those that occur in humans. Such animal models would facilitate development of monitoring methods or therapeutic interventions that are

that are those local
directed systemically or ~~are~~ directed to other areas besides ~~those~~ local anatomic areas where the aneurysm resides. There remains a further need for the identification of markers associated with aneurysm, such as a polymorphism or an "aneurysmal disorder gene(s)," to permit the development of further therapies for intervening at the early stages of the disease or for arresting or slowing its progression.

Summary of the Invention

The invention relates to the discovery that the incidence of an arterial wall disruptive disorders, including but not limited to aortic aneurysm, intra-cranial aneurysm, abdominal aortic aneurysm, and thoracic aortic aneurysm, in a subject correlates with the incidence of Age-Related Macular Degeneration. The present invention therefore provides a novel method for diagnosing arterial wall disruptive disorders or a predisposition to developing arterial wall disruptive disorders, methods for treating or preventing the development of arterial wall disruptive disorders in a subject, by administering to the subject, a pharmaceutically effective amount of a macular degeneration therapeutic, and *in vitro* and *in vivo* assays for screening test compounds to identify arterial wall disruptive disorder therapeutics. It is believed that other forms of macular degeneration in addition to AMD correlate with the incidence of arterial wall disruptive disorders. In a preferred embodiment, a form of aneurysm that is associated with arterial inflammation, degeneration or autoimmunity may correlate with the incidence of AMD. Not to be limited to any particular theory, the aneurysm may be caused at least in part by atherosclerosis or infection. Alternatively, the aneurysm may be caused at least partially by an inherited connective tissue disorder.

In one aspect, the invention provides a method for diagnosing, or determining a predisposition to developing, arterial wall disruptive disorders by detecting one or more markers for macular degeneration in the eye, wherein the marker is indicative of arterial wall disruptive disorders or of a predisposition to developing arterial wall disruptive disorders. Examples of phenotypic markers include: RPE death, immune mediated events, dendritic cells proliferation, migration and differentiation in the sub RPE space (e.g. by detecting the presence or level of a dendritic cell marker such as CD68, CD1a and S100), the presence of disciform scars, the presence of choroidal neovascularization and/or fibrosis in the macula. In a preferred embodiment, the marker is disciform scars and/or choroidal neovascularization (DS/CNV), which is characteristic of the exudative or neovascular (wet) form of macular degeneration. The various immune mediated events that may be detected include detection of auto-antibodies,

of leukocytes

increase

detecting accumulation of leukocytes in the choroid, detecting an increase in HLA-DR immunoreactivity of retinal microglia, detecting an increase in the synthesis of type VI collagen and detecting an up-regulation of an immune associated molecule. The auto-antibodies that may be detected include within their scope antibodies directed against drusen, a RPE antigen or a retinal component. In another aspect, fibrosis in the macula may be detected by determining the presence and level of elastin, fragments of elastin, collagen, or fragments of collagen. Alternatively, fibrosis in the macula may be detected by differential expression of elastin, fibrillin-2, PI-1, PI-2, b-1 integrin, MFAP-1 or MFAP-2.

Examples of genotypic markers include a variety of genes, that are upregulated or downregulated in drusen forming ocular tissue. For example genes expressed by dying RPE cells include: HLA-DR, CD68, vitronectin, apolipoprotein E, clusterin and S-100, heat shock protein 70, death protein, proteasome, Cu/Zn superoxide dismutase, cathepsins, and death adaptor protein RAIDD). Markers involved in immune mediated events include: autoantibodies (e.g. directed against drusen, RPE and/or retina components), leukocytes and type VI collagen. Molecules associated with drusen include: immunoglobulins, amyloid A (α 1 amyloid A), amyloid P component, C5 and C5b-9 terminal complexes, HLA-DR, fibrinogen, Factor X, and prothrombin, complements 3, 5 and 9, complement reactive protein (CRP), immunoglobulin lambda and kappa light chains, Factor X, HLA-DR, apolipoprotein A, apolipoprotein E, antichymotrypsin, β 2 microglobulin, factor X, fibrinogen, prothrombin, thrombospondin, elastin, collagen, and vitronectin. Markers of drusen associated dendritic cells include: CD1a, CD4, CD14, CD68, CD83, CD86, and CD45, PECAM, MMP14, ubiquitin, and FGF. Important dendritic cell-associated accessory molecules that participate in T cell recognition include ICAM-1, LFA1, LFA3, and B7, IL-1, IL-6, IL-12, TNF-alpha, GM-CSF and heat shock proteins. Markers associated with dendritic cell expression include: colony stimulating factor, TNF α , and IL-1. Markers associated with dendritic cell proliferation include: GM-CSF, IL-4, IL-3, SCF, FLT-3 and TNF α . Markers associated with dendritic cell differentiation include IL-10, M-CSF, IL-6 and IL-4.

It would be readily apparent to the skilled artisan that these markers may be detected using one or more techniques known in the art, including but not limited to fundus fluorescein angiography (FFA), fundus ophthalmoscopy or photography (FP), electroretinogram (ERG), electrooculogram (EOG), visual fields, scanning laser ophthalmoscopy (SLO), visual acuity measurements and dark adaptation measurements.

In another embodiment, a sample obtained from a subject is a blood, urine, tissue, DNA or RNA and the marker is detected therein using standard protein or nucleic acid diagnostic

techniques.

In another embodiment, the invention provides a method for diagnosing, or determining a predisposition to, arterial wall disruptive disorders in a subject, comprising isolating a nucleic acid from a subject and genotyping the nucleic acid wherein at least one allele from a macular degeneration-associated haplotype is predictive of an increased risk of arterial wall disruptive disorders. In another embodiment the invention provides a method for diagnosing, or determining a predisposition to arterial wall disruptive disorders in a subject having family members diagnosed with macular degeneration, comprising isolating a nucleic acid from a subject, amplifying the nucleic acid with primers which amplify a region of a chromosome corresponding to a polymorphic marker for AMD and analyzing the amplification product, wherein the presence of a polymorphism indicative of an allele type linked to macular degeneration is indicative of an allele type linked to aortic aneurysm or a predisposition for developing arterial wall disruptive disorders. In yet another embodiment, the invention provides a method for diagnosing, or determining a predisposition to arterial wall disruptive disorders in a subject having family members diagnosed with macular degeneration, comprising isolating a genomic nucleic acid from a subject amplifying short tandem repeat sequences in the genomic DNA to obtain a genotype, comparing the genotype to the genotype of known DNA sequences to detect nucleotide sequence polymorphisms and determining the presence or absence of a polymorphism in the genomic DNA of the subject, wherein the presence of a polymorphism indicative of an allele type linked to macular degeneration is indicative of an allele type linked to arterial wall disruptive disorders or a predisposition for developing arterial wall disruptive disorders. In a preferred embodiment, the genotype substantially corresponds to a region of the short arm of human chromosome 2 bordered by marker D2S2352 and D2S1364. In additional preferred embodiments, the genotype substantially corresponds to one or more of the following chromosomal regions: 1p21-q13, 1q25-q31, 2p16, 6p21.2-cen, 6p21.1, 6q, 6q11-q15, 6q14-q16.2, 6q25-q26, 7p21-p15, 7q31.3-32, not 8q24, 11p12-q13, 13q34, 16p12.1, 17p, 17p13-p12, 17q, 18q21.1-q21.3, 19q13.3, 22q12.1-q13.2 and Xp11.4, all of which have been identified and characterized as harboring a polymorphism or mutation linked to macular degeneration, and as yet unidentified loci that fall on chromosomes 1-22 or X. In a preferred embodiment, the arterial wall disruptive disorders is an AAA or a TAA and the macular degeneration is AMD.

In yet another embodiment, the invention provides a method for diagnosing, or detecting a predisposition to developing, an arterial wall disruptive disorder in a subject, comprising performing an immunoassay on a sample obtained from the subject using an antibody specific for a gene product indicative of macular degeneration, wherein detection of the presence of

indicates that or a
bound antibody indicate the subject has macular degeneration or a predisposition to developing macular degeneration and therefore has an arterial wall disruptive disorder or a predisposition for developing an arterial wall disruptive disorder. In an embodiment, a kit for diagnosing arterial wall disruptive disorders is provided, comprising reagents for performing the immunoassay. In another embodiment, the kit for diagnosing arterial wall disruptive disorders comprises specific primers for amplifying a region of a chromosome having a polymorphism indicative of macular degeneration, reagents for performing DNA amplification and reagents for analyzing the amplified nucleic acid.

In another aspect, the invention provides methods for treating or preventing the development of arterial wall disruptive disorders in a subject by administering a pharmaceutically effective amount of a macular degeneration therapeutic. The macular degeneration therapeutic may be an anti-inflammatory agent, preferably an antagonists of TNF- α , IL-1, GM-CSF, IL-4 or IL-13. The therapeutic may also be IL-10, M-CSF, IL-6 and IL-4 or an agonist thereof. In another embodiment, the macular degeneration therapeutic is a modulator of the expression of one or more DRAMs, such as, for example, amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, β 2 microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin or vitronectin. In another embodiment, the invention provides pharmaceutical compositions useful for treating or preventing arterial wall disruptive disorders, comprising an effective amount of a macular degeneration therapeutic and a therapeutically acceptable carrier. In one embodiment, the arterial wall disruptive disorder is preferably an aortic aneurysm, an AAA or a TAA and the macular degeneration is AMD, and preferably the exudative or neovascular (wet) form which is characterized by disciform scars and/or choroidal neovascularization (DS/CNV).

In another aspect, the invention provides a method for identifying an agent for, or determining the efficacy of, an agent for treating or preventing an arterial wall disruptive disorders in a subject by administering to a subject an agent at a non-toxic dosage and determining whether drusen formation or neovascularization is inhibited or has resolved. In another embodiment, the invention provides a method for identifying an agent for treating or preventing arterial wall disruptive disorder in a subject by contacting a non-human model for macular degeneration with an agent and monitoring one or more markers of macular degeneration, wherein the absence or disappearance of one or more of said markers is indicative of the inhibition of the arterial wall disruptive disorders. The arterial wall disruptive disorders is preferably an AAA or a TAA, and the macular degeneration is preferably AMD, and more

scars and (DS/CNV)
preferably a disciform scar and choroidal neovascularization (DS/CNV) disease type of macular degeneration. The marker used to detect the macular degeneration can be the presence of drusen in the sub RPE space or one or more DRAMs, such as, for example, amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, $\beta 2$ microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin and vitronectin.

In another aspect, the invention provides animal models for arterial wall disruptive disorders that are animals which have or are predisposed for developing AMD, wherein the presence of, severity of, or predisposition for AMD in the animal is indicative of the presence of, severity of, or predisposition for arterial wall disruptive disorders. In one embodiment, the animal is a transgenic animal. In another embodiment, the animal has been treated to develop AMD.

Other features and advantages of the invention will be apparent from the following figures, detailed description, and claims.

Detailed Description of the Invention

The invention relates to the discovery that the incidence of certain arterial wall disruptive disorders correlates with the incidence of Age-Related Macular Degeneration. In one embodiment, described in detail herein, the invention relates to the discovery that the incidence of aneurysmal disorders correlates with the incidence of Age-Related Macular Degeneration. While the invention will be described by particular reference to aortic aneurysmal disorders, it is understood that those pathological processes implicated in these disorders are at work on a more generalized basis within the vascular system. (Baxter BT, et al., "Abdominal aortic aneurysms are associated with altered matrix proteins of nonaneurysmal aortic segments", J Vasc Surg, 19(5):797-802; discussion 803 1994 May.) Other locations for aneurysmal disorders are familiar to practitioners in the relevant arts. In certain of these locations, pathological processes have been identified that are similar to those detected in aortic aneurysms. For example, pathological processes have been identified in aneurysm formation in the cerebral vasculature that are similar to those associated with aortic aneurysms. (Gaetani P, et al., "Metalloproteases and intracranial vascular lesions", Neurol Res, 21(4):385-90 1999 Jun). However, the anatomy of the aorta, with its variable distribution of structural elements such as collagen and elastin, makes this vessel a particularly exemplary one to study. (Halloran BG, et al., "Localization of aortic disease is associated with intrinsic differences in aor," J Surg Res, 59(1):17-22 1995 Jul). Hence, while

the present invention will ^{be illustrated} ~~illustrated~~ by reference to the aorta, it ^{is understood} ~~is understood~~ that the kits and methods described herein may be related to the presence of arterial wall disruptive disorder in any artery of the body.

4.1: Definitions

The meaning of certain terms and phrases as used in the following detailed description and claims are defined as follows:

The term "agonist", as used herein, is meant to refer to an agent that enhances or upregulates (e.g., potentiates or supplements) the production or activity of a gene product. An agonist can also be a compound which increases the interaction of a gene product, molecule or cell with another gene product, molecule or cell, e.g., of a gene product with another homologous or heterologous gene product, or of a gene product with its receptor. A preferred agonist is a compound which enhances or increases binding or activation of a transcription factor to an upstream region of a gene and thereby activates the gene. Any agent that activates gene expression, e.g., by increasing RNA or protein synthesis or decreasing RNA or protein turnover, or gene product activity may be an agonist whether the agent acts directly on the gene or gene product or acts indirectly, e.g., upstream in the gene regulation pathway. Agonists may be RNAs, peptides, antibodies and small molecules, or a combination thereof.

The phrase "AMD associated fundus findings," refers to those abnormal findings indicative of AMD. As examples, AMD associated fundus findings may include the presence of multiple drusen in the periphery, a greyish macula, peripapillary atrophy, choroidal neovascular membrane and/or disciform scars or geographic atrophy (GA). AMD associated fundus findings may include those findings detected in vivo by conventional optical methods known in the ophthalmological arts or by any other method that is non-destructive to the fundus.

The term "animal model", as used herein, includes transgenic animals, naturally occurring animals with genetic mutations and non-transgenic animals that have been treated with one or more agents, or combinations thereof (e.g., a *skid* mouse), any of which may serve as experimental models for a disease, e.g., macular degeneration or aortic aneurysm. For example, a transgenic mouse may be a mouse in which a gene is knocked out or in which a gene is overexpressed.

The term "antagonist" as used herein is meant to refer to an agent that downregulates (e.g., suppresses or inhibits) the production or activity of a gene product. Such an antagonist can be an agent which inhibits or decreases the interaction between a gene product, molecule or cell and another gene product, molecule or cell. A preferred antagonist is a compound which inhibits

activation

upstream

or decreases binding or ~~activation~~ of a transcription factor to an ~~upstream~~ region of a gene and thereby blocks activation of the gene. Any agent that inhibits gene expression or gene product activity may be an antagonist whether the agent acts directly on the gene or gene product or acts indirectly, e.g., upstream in the gene regulation pathway. An antagonist can also be a compound that downregulates expression of a gene or which reduces the amount of gene product present, e.g., by decreasing RNA or protein synthesis or increasing RNA or protein turnover. Antagonists may be RNAs, peptides, antibodies and small molecules, or a combination thereof.

The term "arterial wall disruptive disorder" refers to those abnormalities of arterial walls characterized by the formation of aneurysms or by the formation of frank disruptions such as dissections.

The term "associate" or "interact" as used herein is meant to include detectable relationships or associations (e.g., biochemical interactions) between molecules, such as interaction between protein-protein, protein-nucleic acid, nucleic acid-nucleic acid, protein-carbohydrate, carbohydrate-carbohydrate, protein-lipid, lipid-lipid, etc., and protein-small molecule or nucleic acid-small molecule in nature.

The term "dendritic cell" or "DC" as used herein refers to hematopoietic cells characterized by their unusual dendritic morphology, their potent antigen-presenting capability and their lack of lineage-specific markers such as CD3, CD19, CD16, CD14, which distinguishes them respectively from T cells, B cells, NK cells, and monocytes. Currently there are at least two ontogenic pathways for dendritic cell development: those that derive from myeloid-committed hematopoietic precursors and those that derive from lymphoid-committed hematopoietic precursors. Myeloid-committed precursors which give rise to granulocytes and monocytes can also differentiate into Langerhans cells of the skin and myeloid related dendritic cells in the secondary lymphoid tissue. (See Lotze, M.T. and Thomson, A.W. (Eds.) (1999) "Dendritic Cells", Academic Press, San Diego, CA, for a number of reviews on dendritic cells, the teachings of which are incorporated herein by reference).

The term "dendritic cell precursor" or "DC precursor" as used herein refers to cell types from which a dendritic cell is derived upon differentiation and maturation. A dendritic cell precursor may be a bone marrow stem cell, a lymphoid cell lineage-committed cell or a myeloid cell lineage-committed cell from which a dendritic cell may develop after exposure to certain DCRMs. For example, DC precursors of the myeloid lineage can be induced to differentiate into DCs by treatment with GM-CSF.

The term "dendritic cell process" refers to a portion of a dendritic cell which projects or extends away from the center of the dendritic cell.

disorder

clinical

A "disease" is a disorder, as defined herein, characterized by clinical events including clinical symptoms and clinical signs. Clinical symptoms are those experiences reported by a patient that indicate to the clinician the presence of pathology. Clinical signs are those objective findings on physical or laboratory examination that indicate to the clinician the presence of pathology.

A "disorder" refers broadly to any abnormality of an organ, whether structural, histological, biochemical or any other abnormality.

The term "drusen" as used herein encompasses a number of phenotypes, all of which develop, between the inner collagenous layer of Bruch's membrane and the RPE basal lamina.

Hard drusen are small distinct deposits comprised of homogeneous eosinophilic material and are usually round or hemispherical, without sloped borders. Soft drusen are larger, usually not homogeneous, and typically contain inclusions and spherical profiles. Some drusen may be calcified. The term "diffuse drusen," or "basal linear deposit," is used to describe the amorphous material which forms a layer between the inner collagenous layer of Bruch's membrane and the retinal pigment epithelium (RPE). This material can appear similar to soft drusen histologically, with the exception that it is not mounded.

The term "drusen associated marker" refers to a phenotype or genotype that is involved with the development of drusen formation and ultimately the development of a drusen associated ocular disease or disorder. Examples of phenotypic markers include: dysfunctional and/or RPE death, immune mediated events, dendritic cells proliferation, migration and differentiation extrusion of the DC process into the sub RPE space (e.g. by detecting the presence or level of a dendritic cell marker such as CD68, CD1a and S100), the presence of geographic atrophy or disciform scars, the presence of choroidal neovascularization and/or choroidal fibrosis, especially in the macula. Examples of genotypic markers include mutant genes and/or a distinct pattern of differential gene expression (Drusen Development Pathway"), including genes that are upregulated or downregulated in drusen forming ocular tissue associated with drusen biogenesis. For example genes expressed by dysfunctional and/or dying RPE cells include: HLA-DR, CD68, vitronectin, apolipoprotein E, clusterin and S-100, heat shock protein 70, death protein, proteasome, Cu/Zn superoxide dismutase, cathepsins, and death adaptor protein RAIDD.

Markers involved in immune mediated events include: autoantibodies (e.g. directed against drusen, RPE and/or retina components), leukocytes, dendritic cells, myofibroblasts, type VI collagen, and a cadre of chemokines and cytokines. Molecules associated with drusen include: immunoglobulins, amyloid A, amyloid P component, HLA-DR, fibrinogen, Factor X, prothrombin, complements 3, 5, 9, and 56-9, creactive protein (CRP) apolipoprotein A,

antichymotrypsin

thrombospondin,

apolipoprotein E, antichymotrypsin, β 2 microglobulin, thrombospondin and vitronectin autoantibodies (e.g. directed against drusen, RPE and/or retina components), leukocytes and type VI collagen. Molecules associated with drusen include: immunoglobulins, amyloid A (α 1 amyloid A), amyloid P component, C5 and C5b-9 terminal complexes, HLA-DR, fibrinogen, Factor X, and prothrombin, complements 3, 5 and 9, complement reactive protein (CRP), immunoglobulin lambda and kappa light chains, Factor X, HLA-DR, apolipoprotein A, apolipoprotein E, antichymotrypsin, β 2 microglobulin, factor X, fibrinogen, prothrombin, thrombospondin, elastin, collagen, and vitronectin. Markers of drusen associated dendritic cells include: CD1a, CD4, CD14, CD68, CD83, CD86, and CD45, PECAM, MMP14, ubiquitin, and FGF. Important dendritic cell-associated accessory molecules that participate in T cell recognition include ICAM-1, LFA1, LFA3, and B7, IL-1, IL-6, IL-12, TNF-alpha, GM-CSF and heat shock proteins. Markers associated with dendritic cell expression include: colony stimulating factor, TNF α , and IL-1. Markers associated with dendritic cell proliferation include: GM-CSF, IL-4, IL-3, SCF, FLT-3 and TNF α . Markers associated with dendritic cell differentiation include IL-10, M-CSF, IL-6 and IL-4.

The term "drusen-associated ocular disease" as used herein refers to any disease in which drusen formation takes place and for which drusen causes or contributes thereto. Macular degenerations, the accumulation of drusen creates a physical barrier that appears to impede normal metabolite and waste diffusion between the choriocapillaris and the retina. As a result, the diffusion of oxygen, glucose, and other nutritive or regulatory serum-associated molecules required to maintain the health of the retina and RPE are inhibited.

A "drusen-associated molecule" or "DRAM" as used herein refers to any protein, carbohydrate, glycoconjugate (e.g., glycoprotein or glycolipid), other lipid, nucleic acid or other molecule which is found in association with, or interacting with, a drusen deposit. DRAMS may include cellular fractions or organelles that are not normally found deposited in, or in association with, a tissue unless it is affected by drusen or which is not present in drusen-affected and normal tissue in equivalent amounts.

The term "extracellular matrix" ("ECM") refers to, e.g., the collagens, proteoglycans, non-collagenous glycoproteins and elastins that surround cells and provide structural and functional support for cells as well as maintain various functions of cells, such as cell adhesion, proliferation, differentiation and protein synthesis. A skilled artisan will appreciate that the precise composition and physical properties of ECM, as well as its function, vary between various cell types, between various tissues, and between various organs.

A "fibrosis associated reaction" is any process that relates to tissue repair, including the

vessels proliferation
formation of new blood vessels (angiogenesis), the migration and proliferation of fibroblasts, the deposition of extracellular matrix and the maturation and organization of fibrous tissue.

An "immune mediated event" refers to any event that occurs as part of the processes of acute or chronic inflammation. The histological, biochemical and genetic processes of acute and chronic inflammation are familiar to practitioners of ordinary skill in the art.

The term "inhibit" as used herein means to prevent or prohibit and is intended to include total inhibition, partial inhibition, reduction or decrease.

The term "macular degeneration" refers to any of a number of conditions in which the retinal macula degenerates or becomes dysfunctional, e.g., as a consequence of decreased growth of cells of the macula, increased death or rearrangement of the cells of the macula (e.g., RPE cells, loss of normal biological function, or a combination of these events. Macular degeneration results in the loss of integrity of the histoarchitecture of the cells of the normal macula and/or the loss of function of the cells of the macula. Any condition which alters or damages the integrity or function of the macula (e.g., damage to the RPE or Bruch's membrane) may be considered to fall within the definition of macular degeneration. Other examples of diseases in which cellular degeneration has been implicated include retinal detachment, chorioretinal degenerations, retinal degenerations, photoreceptor degenerations, RPE degenerations, mucopolysaccharidoses, rod-cone dystrophies, cone-rod dystrophies and cone degenerations.

The term "marker" is used herein to refer to any phenotype or genotype that is characteristic of a disorder or a disease. The phenotype may include physical findings, biochemical components, or any molecule or gene product which is upregulated or downregulated in the disorder or disease, and when measured is therefore indicative of the disorder or disease when levels are measured. Genotypes that can act as markers include any polymorphism or mutation that is associated with a particular disorder or disease.

The terms "modulation", "alteration", "modulate", or "alter" are used interchangeably herein to refer to both upregulation (i.e., activation or stimulation (e.g., by agonizing or potentiating)) and downregulation (i.e., inhibition or suppression (e.g., by antagonizing, decreasing or inhibiting)) of an activity. For example, the activity that is modulated may be gene expression or may be the growth, proliferation, migration or differentiation of dendritic cells.

"Modulates" or "alters" is intended to describe both the upregulation or downregulation of a process, since, as is well known to a skilled artisan, a process which is upregulated by a certain stimulant may be inhibited by an antagonist to that stimulant. Conversely, a process that is downregulated by a certain stimulant may be inhibited by an antagonist to that stimulant. Thus, e.g., the identification of an agent that induces a cellular response modulates or alters cellular

behavior in an inductive ^{manner} ~~her~~ and it is inherently understood ^{that the} ~~that~~ response may be modulated in an inhibitory manner by an inhibitor of that agent (e.g., by an antibody or antisense RNA, as is well understood and described in the art).

The term "nucleic acid" as used herein refers to polynucleotides or oligonucleotides such as deoxyribonucleic acid (DNA), and, where appropriate, ribonucleic acid (RNA). The term should also be understood to include, as equivalents, analogs of either RNA or DNA made from nucleotide analogs and as applicable to the embodiment being described, single (sense or antisense) and double-stranded polynucleotides.

The term "physical finding," as the term is used herein, refers to any sign or symptom that is elicitable during the face-to-face evaluation of a patient by a health care provider. A physical finding then may include a symptom, such as pain, described by the patient during medical history-taking. A physical finding may refer to those features of the patient's anatomy identified during the observation, auscultation, percussion or palpation of the patient's body. A physical finding may also refer to those aspects of the patient's anatomy that are discerned by observation, auscultation, percussion or palpation amplified by instrumentation directly manipulated by the health care provider, instrumentation such as endoscopes, stethoscopes, otoscopes and fundoscopes. Other, more sophisticated instruments for observation, such as slit lamps, are capable of discerning "physical findings," as the term is used herein. Within the scope of this invention are those findings produced by amplifying the observational capacity of the health care provider during the direct encounter with the patient. For example, administering fluorescein and observing its effect on a tissue with a slit lamp at a preselected wavelength would result in the determination of a set of physical findings, as the term is used herein. Other types of physical findings consistent with this definition will be readily apparent to practitioners of ordinary skill in the relevant arts. Physical findings for aortic aneurysms could include, for example, a pulsatile abdominal mass, a tender abdominal mass, back pain, alteration of peripheral pulses or an abdominal bruit.

The term "polymorphism" refers to the coexistence of more than one form of a gene or portion (e.g., allelic variant) thereof. A portion of a gene of which there are at least two different forms, i.e., two different nucleotide sequences, is referred to as a "polymorphic region of a gene". A polymorphic region can be a single nucleotide, the identity of which differs in different alleles. A polymorphic region can also be several nucleotides long. A "polymorphic gene" refers to a gene having at least one polymorphic region.

The terms "protein", "polypeptide" and "peptide" are used interchangeably herein when referring to a gene product comprising amino acids. The term "recombinant protein" refers to a

present invention

recombinant DNA

polypeptide of the ~~present invention~~ which is produced by ~~recombinant DNA~~ techniques, wherein generally DNA encoding a polypeptide is inserted into a suitable expression vector which is in turn used to transform a host cell to produce the heterologous protein. Likewise the term "recombinant nucleic acid" or "recombinant DNA" refers to a nucleic acid or DNA of the present invention which is produced by recombinant DNA techniques, wherein generally DNA encoding a polypeptide is inserted into a suitable expression vector which is in turn used to transform a host cell to produce the heterologous protein. Moreover, the phrase "derived from", with respect to a recombinant gene, is meant to include within the meaning of "recombinant protein" those proteins having an amino acid sequence of a native polypeptide, or an amino acid sequence similar thereto which is generated by mutations including substitutions and deletions (including truncation) of a naturally occurring form of the polypeptide.

A "radiological finding," as used herein, refers to any digital or graphic representation resulting from the diagnostic administration of a dose of electromagnetic radiation or sound waves to a patient. A radiological finding would include the output of tests such as MRI, CT scan, IV contrast angiography, conventional XRay, ultrasound, echocardiography, doppler angiography, or radionuclide scans. Other types of radiological findings will be apparent to practitioners of ordinary skill in the medical arts. Radiological findings consistent with a AAA might include, for example, calcification on lateral lumbosacral spine films, a mass discernible on ultrasound, or a characteristic appearance of the infrarenal aorta on angiography, CT scan or MRI.

"Small molecule" as used herein, is meant to refer to a composition which has a molecular weight of less than about 5 kD and most preferably less than about 4 kD. Small molecules can be nucleic acids, peptides, polypeptides, peptidomimetics, carbohydrates, lipids (e.g., glycolipids and pig-tail lipids) or other organic (carbon containing) or inorganic molecules. Many pharmaceutical companies have extensive libraries of chemical and/or biological mixtures, often fungal, bacterial, or algal extracts, which can be screened with any of the assays of the invention to identify therapeutic compounds.

A "therapeutic" as used herein refers to an agonist or antagonist of the bioactivity of a drusen associated marker. Preferred therapeutics reduce or inhibit RPE cell death, factors involved in the inflammatory response, factors involved in fibroblast proliferation and migration resulting in fibrosis and/or dendritic cell proliferation, migration or differentiation into drusen.. Other preferred therapeutics include agents that have shown some efficacy in treating or preventing aortic diseases (e.g. AAA), including: antiinflammatory agents (e.g. anti CD-18 antibody), protease inhibitors, inhibitors of elastolytic MMPs (e.g. the hydroxamate based

antibiotics

inhibitors

RS312908, batimastat, antibiotics (e.g. doxycycline), tetracycline), inhibitors of prostaglandin synthesis and beta-blockers (e.g. propranolol).

The term "transcriptional regulatory sequence" is a generic term used throughout the specification to refer to DNA sequences, such as initiation signals, enhancers, and promoters, which induce or control transcription of protein coding sequences with which they are operably linked.

As used herein, the term "transfection" means the introduction of a nucleic acid, e.g., via an expression vector, into a recipient cell by nucleic acid-mediated gene transfer.

"Transformation", as used herein, refers to a process in which a cell's genotype is changed as a result of the cellular uptake of exogenous DNA or RNA.

As used herein, the term "transgene" means a nucleic acid sequence (encoding, e.g., one of the polypeptides of the invention, or an antisense transcript thereto) which has been introduced into a cell. A transgene could be partly or entirely heterologous, i.e., foreign, to the transgenic animal or cell into which it is introduced, or can be homologous to an endogenous gene of the transgenic animal or cell into which it is introduced, but which is designed to be inserted, or is inserted, into the animal's genome in such a way as to alter the genome of the cell into which it is inserted (e.g., it is inserted at a location which differs from that of the natural gene or its insertion results in a knockout or may result in over expression). A transgene can also be present in a cell in the form of an episome. A transgene can include one or more transcriptional regulatory sequences and any other nucleic acid, such as 5' UTR sequences, 3' UTR sequences, or introns, that may be necessary for optimal expression of a selected nucleic acid.

A "transgenic animal" refers to any animal, preferably a non-human mammal, bird or an amphibian, in which one or more of the cells of the animal contain heterologous nucleic acid introduced by way of human intervention, such as by transgenic techniques well known in the art. The nucleic acid is introduced into the cell, directly or indirectly by introduction into a precursor of the cell, by way of deliberate genetic manipulation, such as by microinjection or by infection with a recombinant virus. The term genetic manipulation does not include classical cross-breeding, or *in vitro* fertilization, but rather is directed to the introduction of a recombinant DNA molecule. This molecule may be integrated within a chromosome, or it may be extrachromosomally replicating DNA. In the typical transgenic animals described herein, the transgene causes cells to fail to express a specific normal gene product, to express a recombinant form of one or more DRAM polypeptides, e.g., either agonistic or antagonistic forms, or molecules that regulate the biosynthesis, accumulation or resorption of DRAMs or dendritic

Knockouts may cause cells. Transgenic knockouts may, for example, be produced which cause alterations in dendritic cell behavior (e.g., cell growth, proliferation, migration, differentiation or gene expression). For example, mice whose Rel-B, transforming growth factor b1 (TGF-b1) or *Ikaros* genes are disrupted lack dendritic cells from various cell lineages (see Caux, C. et al., 1999). However, transgenic animals in which the recombinant DCRM or DRAM gene is silent are also contemplated, as for example, the FLP or CRE recombinase dependent constructs. Moreover, "transgenic animal" also includes those recombinant animals in which gene disruption is caused by human intervention, including both recombination and antisense techniques.

The term "treating" as used herein is intended to encompass curing as well as ameliorating at least one symptom of the condition or disease.

The terms "vector," "cloning vector," or "replicative cloning vector," are interchangeable as used herein, and refer to a nucleic acid molecule, which is capable of transporting another nucleic acid to which it has been linked. One type of preferred vector is an episome, i.e., a nucleic acid capable of extra-chromosomal replication. Preferred vectors are those capable of autonomous replication and/or expression of nucleic acids to which they are linked. Vectors capable of directing the expression of genes to which they are operatively linked are referred to herein as "expression vectors." The term "expression system" as used herein refers to an expression vector under conditions whereby an mRNA may be transcribed and/or an mRNA may be translated into protein. The expression system may be an *in vitro* expression system, which is commercially available or readily made according to art known techniques, or may be an *in vivo* expression system, such as a eukaryotic or prokaryotic cell containing the expression vector. In general, expression vectors of utility in recombinant DNA techniques are often in the form of "plasmids" which refer generally to circular double stranded DNA loops which, in their vector form are not bound to the chromosome. In the present specification, "plasmid" and "vector" are used interchangeably as a plasmid is the most commonly used form of vector. However, the invention is intended to include such other forms of expression vectors which serve equivalent functions and which become known in the art subsequently hereto.

The term "wild-type allele" refers to an allele of a gene which, when present in two copies in a subject results in a wild-type phenotype. There can be several different wild-type alleles of a specific gene, since certain nucleotide changes in a gene may not affect the phenotype of a subject having two copies of the gene with the nucleotide changes.

4.2: Pathophysiology of Macular Degeneration and Arterial Wall Disruptive Disorders

In one embodiment, the methods and kits of the present invention rely upon the novel

herein that pathophysiological and
discovery disclosed herein that there are significant pathophysiological and biological
similarities between those patients afflicted with AMD and those patients afflicted with arterial
wall disruptive disorders, in particular AAA. Some of these similarities are summarized below:

5

AAA/AMD Similarities

AAA Features	AMD	Data Support
Heritable	X	
Age-related	X	
Elastin destruction & other ECM	X	University of Iowa data
Collegen and elastin neosynthesis	X	University of Iowa data
Exacerbated by hypertension	?	
Smoking as a risk factor	X	
Autoimmune involvement	?	University of Iowa data
Aortic neovascularization	X	
Assoc. with atherosclerosis	X	
Potential assoc. with COPD	?	University of Iowa data
Loss of vascular smooth muscle cells	?	University of Iowa data
Influx of dendritic cells	X	University of Iowa data
Chronic inflammation (subset)	?	University of Iowa data
Upregulation of MMP2 & MMP9, t-PA, uPA, PAI-1, C3, IgG, TNFX, IL1, IL6, IL8	X	
Downreg. of TIMP, GAG, PG	?	
Assoc. with alpha-1 antitrypsin deficiency (subset)	?	University of Iowa data

Certain of these associations are supported by data presented in more detail in the Examples incorporated herein. Other associations not specified above will be readily apparent to practitioners of ordinary skill in the relevant arts. The descriptions presented below of the disease processes of macular degeneration and arterial wall disruptive disorder will allow the ordinarily skilled practitioner to determine, with no more than routine experimentation, other associations between these disease processes that will fall within the scope of the present invention.

4.2a: Macular Degeneration

4.2a(i) General

Macular degeneration is a clinical term that is used to describe a variety of diseases that are all characterized by a progressive loss of central vision associated with abnormalities of Bruch's membrane, the neural retina and the retinal pigment epithelium (RPE). These disorders include very common conditions that affect older patients (age-related macular degeneration or AMD) as well as rarer, earlier-onset dystrophies that in some cases can be detected in the first decade of life (Best F. Z., *Augenheilkd.*, 13:199-212, 1905; Sorsby, A., et al., *Br J. Ophthalmol.* 33:67-97, 1949; Stargardt, K., *Albrecht Von Graefes Arch Klin Exp Ophthalmol.* 71: 534-550, 1909; Ferrell, R. E., et al., *Am J. Hum Genet.* 35:78-84, 1983; Jacobson, D. M., et al., *Ophthalmology*, 96:885-895, 1989; Small, K. W., et al. *Genomics* 13:681-685, 1992; Stone, E. M., et al., *Nature Genet.* 1:246-250, 1992; Forsman, K., et al. *Clin Genet.* 42:156-159, 1992; Kaplan, J. S., et al. *Nature Genet.* 5:308-311, 1993; Stone, E. M., et al. *Arch Ophthalmol.* 112:763-772, 1994; Zhang, K., et al. *Arch Ophthalmol.* 112:759-764, 1994; Evans, K., et al. *Nature Genet.* 6:210-213, 1994; Kremer, H., et al. *Hum Mol Genet.* 3:299-302, 1994; Kelsell, R. E., et al. *Hum Mol Genet.* 4:1653-1656, 1995; Nathans, J., et al. *Science* 245:831-838, 1989; Wells, J., et al. *Nature Genet.* 3:213-218, 1993; Nichols, B. E., et al. *Nature Genet.* 3:202-207, 1993a; Weber, B. H. F., et al. *Nature Genet.* 8:352-355, 1994). Macular degeneration diseases include, for example, Age Related Macular Degeneration, North Carolina macular dystrophy, Sorsby's fundus dystrophy, Stargardt's disease, pattern dystrophy, Best disease, malattia leventinese, Doyme honeycomb choroiditis, dominant drusen and radial drusen.

Age-related macular degeneration, or AMD, is associated with progressive diminution of visual acuity in the central portion of the visual field, changes in color vision, and abnormal dark adaptation and sensitivity (Steinmetz, et al., 1993; Brown & Lovie-Kitchin, 1983; Brown, et al., 1986; Sunness, et al., 1985; Sunness, et al., 1988; Sunness, et al., 1989; Eisner, et al., 1987; Massof, et al., 1989; Chen, et al., 1992).

leading cause

America and

AMD is the leading cause of legal blindness in North America and Western Europe (Hyman, 1992) and has become a significant health problem as the percentage of individuals above the age of 50 increases. In the Beaver Dam, Wisconsin population, the incidence of AMD was estimated to be 9.2% for persons over the age of 40 (Klein, et al., 1995). The Framingham Eye Study found the overall incidence of AMD to be 8.8%, with a 27.9% incidence in the 75-85 year old population (Kahn, et al., 1977; Leibowitz, et al., 1980). In an Australian study, 18.5% of those over age 85 were estimated to be afflicted with AMD (O'Shea, 1996). Variations in estimated incidence are likely a result of the use of different criteria for a diagnosis of AMD in different studies, or they may result from different risk factors among the various populations studied.

A number of population-based studies indicate that AMD has a genetic component, based upon the examination of the rates of AMD in different racial groups and the degree of familial aggregation of AMD (Hyman, et al., 1983). For example, Caucasians appear to be at greater risk than individuals of Hispanic origin (Cruickshanks, et al., 1997). In addition, a black population on Barbados had a lower incidence of advanced AMD than the local Caucasian population (Schachat, et al., 1995). Studies involving twins and other siblings have demonstrated that, the more related two individuals are, the more likely they are to be at the same risk of developing AMD (Heiba, et al., 1994; Klein, et al., 1994; Meyers and Zacchary, 1988; Meyers, 1994; Meyers, et al., 1995; Piguet, et al., 1993; Seddon, et al., 1997; Silvestri, et al., 1994). These findings suggest that heredity contributes significantly to an individual's risk of developing AMD, but the gene(s) responsible have not been identified. Although a recent report suggested that mutations in the photoreceptor ABCR rim protein cause up to 15% of AMD cases in the United States (Allikmets, et al., 1997), more recent data has shown this not to be the case (De La Paz, et al., 1998; Stone et al., 1998). Thus, no gene accounting for all AMD has been identified.

Other maculopathies, typically with an earlier onset of symptoms than AMD, have been described. These include North Carolina macular dystrophy (Small, et al., 1993), Sorsby's fundus dystrophy (Capon, et al., 1989), Stargardt's disease (Parodi, 1994), pattern dystrophy (Marmor and Byers, 1977), Best disease (Stone, et al., 1992), dominant drusen (Deutman and Jansen, 1970), and radial drusen ("malattia leventinese") (Heon, et al., 1996). Several of these inherited disorders, including those that map to distinct chromosomal loci or for which the genes have been identified, are characterized by the presence of drusen (or other extracellular deposits in the subRPE space). Based on this information, it is likely that: (1) AMD is not a single, genetic disease, since different diseases with distinct chromosomal loci share morphologic differences (Holz, et al., 1995a; Mansergh et al., 1995; and (2) that drusen may develop as a

pathway
insults, genetic
result of a biological pathway induced by a variety of different insults, genetic or otherwise. AMD may actually be several diseases most of which are genetic, with environmental factors play some role in its development.

A number of gene loci have been reported as indicating a predisposition to macular degeneration: 1p21-q13, for recessive Stargardt's disease or fundus flavi maculatus (Allikmets, R. et al. *Science* 277:1805-1807, 1997; Anderson, K. L. et al., *Am. J. Hum. Genet.* 55:1477, 1994; Cremers, F. P. M. et al., *Hum. Mol. Genet.* 7:355-362, 1998; Gerber, S. et al., *Am. J. Hum. Genet.* 56:396-399, 1995; Gerber, S. et al., *Genomics* 48:139-142, 1998; Kaplan, J. et al., *Nat. Genet.* 5:308-311, 1993; Kaplan, J. et al., *Am. J. Hum. Genet.* 55:190, 1994; Martinez-Mir, A. et al., *Genomics* 40:142-146, 1997; Nasonkin, I. et al., *Hum. Genet.* 102:21-26, 1998; Stone, E. M. et al., *Nat. Genet.* 20:328-329, 1998); 1q25-q31, for recessive age related macular degeneration (Klein, M. L. et al., *Arch. Ophthalmol.* 116:1082-1088, 1988); 2p16, for dominant radial macular drusen, dominant Doyme honeycomb retinal degeneration or Malattia Leventinese (Edwards, A. O. et al., *Am. J. Ophthalmol.* 126:417-424, 1998; Heon, E. et al., *Arch. Ophthalmol.* 114:193-198, 1996; Heon, E. et al., *Invest. Ophthalmol. Vis. Sci.* 37:1124, 1996; Gregory, C. Y. et al., *Hum. Mol. Genet.* 7:1055-1059, 1996); 6p21.2-cen, for dominant macular degeneration, adult vitelloform (Felbor, U. et al. *Hum. Mutat.* 10:301-309, 1997); 6p21.1 for dominant cone dystrophy (Payne, A. M. et al. *Am. J. Hum. Genet.* 61:A290, 1997; Payne, A. M. et al., *Hum. Mol. Genet.* 7:273-277, 1998; Sokol, I. et al., *Mol. Cell.* 2:129-133, 1998); 6q, for dominant cone-rod dystrophy (Kelsell, R. E. et al. *Am. J. Hum. Genet.* 63:274-279, 1998); 6q11-q15, for dominant macular degeneration, Stargardt's-like (Griesinger, I. B. et al., *Am. J. Hum. Genet.* 63:A30, 1998; Stone, E.M. et al., *Arch. Ophthalmol.* 112:765-772, 1994); 6q14-q16.2, for dominant macular degeneration, North Carolina Type (Kelsell, R. E. et al., *Hum. Mol. Genet.* 4:653-656, 1995; Robb, M. F. et al., *Am. J. Ophthalmol.* 125:502-508, 1998; Sauer, C. G. et al., *J. Med. Genet.* 34:961-966, 1997; Small, K. W. et al., *Genomics* 13:681-685, 1992; Small, K. W. et al., *Mol. Vis.* 3:1, 1997); 6q25-q26, dominant retinal cone dystrophy 1 (Online Mendelian Inheritance in Man (TM). Center for Medical Genetics, Johns Hopkins University, and National Center for Biotechnology Information, National Library of Medicine. <http://www3.ncbi.nlm.nih.gov/omim> (1998); 7p21-p15, for dominant cystoid macular degeneration (Inglehearn, C. F. et al., *Am. J. Hum. Genet.* 55:581-582, 1994; Kremer, H. et al., *Hum. Mol. Genet.* 3:299-302, 1994); 7q31.3-32, for dominant tritanopia, protein: blue cone opsin (Fitzgibbon, J. et al., *Hum. Genet.* 93:79-80, 1994; Nathans, J. et al., *Science* 193:193-232, 1986; Nathans, J. et al., *Ann. Rev. Genet.* 26:403-424, 1992; Nathans, J. et al., *Am. J. Hum. Genet.* 53:987-1000, 1993; Weitz, C. J. et al., *Am. J. Hum. Genet.* 50:498-507, 1992; Weitz, C. J. et al.,

Am. J. Hum. Genet. 51:446, 1992); not 8q24, for dominant ~~ma~~ degeneration, atypical vitelliform (Daiger, S. P. et al., In 'Degenerative Retinal Diseases', LaVail, et al., eds. Plenum Press, 1997; Ferrell, R. E. et al., *Am. J. Hum. Genet.* 35:78-84, 1983; Leach, R. J. et al., *Cytogenet. Cell Genet.* 75:71-84, 1996; Sohocki, M. M. et al., *Am. J. Hum. Genet.* 61:239-241, 1997); 11p12-q13, for dominant macular degeneration, Best type (bestrophin) (Forsman, K. et al., *Clin. Genet.* 42:156-159, 1992; Graff, C. et al., *Genomics*, 24:425-434, 1994; Petrukhin, K. et al., *Nat. Genet.* 19:241-247, 1998; Marquardt, A. et al., *Hum. Mol. Genet.* 7:1517-1525, 1998; Nichols, B. E. et al., *Am. J. Hum. Genet.* 54:95-103, 1994; Stone, E. M. et al., *Nat. Genet.* 1:246-250, 1992; Wadeilus, C. et al., *Am. J. Hum. Genet.* 53:1718, 1993; Weber, B. et al., *Am. J. Hum. Genet.* 53:1099, 1993; Weber, B. et al., *Am. J. Hum. Genet.* 55:1182-1187, 1994; Weber, B. H., *Genomics* 20: 267-274, 1994; Zhaung, Z. et al., *Am. J. Hum. Genet.* 53:1112, 1993); 13q34, for dominant macular degeneration, Stargardt type (Zhang, F. et al., *Arch. Ophthalmol.* 112:759-764, 1994); 16p12.1, for recessive Batten disease (ceroid-lipofuscinosis, neuronal 3), juvenile; protein:Batten disease protein (Batten Disease Consortium, *Cell* 82:949-957, 1995; Eiberg, H. et al., *Clin. Genet.* 36:217-218, 1989; Gardiner, M. et al., *Genomics* 8:387-390, 1990; Mitchison, H. M. et al., *Am. J. Hum. Genet.* 57:312-315, 1995; Mitchison, H. M. et al., *Am. J. Hum. Genet.* 56:654-662, 1995; Mitchison, H. M. et al., *Genomics* 40:346-350, 1997; Munroe, P. B. et al., *Am. J. Hum. Genet.* 61:310-316, 1997; 17p, for dominant areolar choroidal dystrophy (Lotery, A. J. et al., *Ophthalmol. Vis. Sci.* 37:1124, 1996); 17p13-p12, for dominant cone dystrophy, progressive (Balciuniene, J. et al., *Genomics* 30:281-286, 1995; Small, K. W. et al., *Am. J. Hum. Genet.* 57:A203, 1995; Small, K. W. et al., *Am. J. Ophthalmol.* 121:13-18, 1996); 17q, for cone rod dystrophy (Klystra, J. A. et al., *Can. J. Ophthalmol.* 28:79-80, 1993); 18q21.1-q21.3, for cone-rod dystrophy, de Grouchy syndrome (Manhant, S. et al., *Am. J. Hum. Genet.* 57:A96, 1995; Warburg, M. et al., *Am. J. Med. Genet.* 39:288-293, 1991); 19q13.3, for dominant cone-rod dystrophy; recessive, dominant and 'de novo' Leber congenital amaurosis; dominant RP; protein: cone-rod otx-like photoreceptor homeobox transcription factor (Bellingham, J. et al., In 'Degenerative Retinal Diseases', LaVail, et al., eds. Plenum Press, 1997; Evans, K. et al., *Nat. Genet.* 6:210-213, 1994; Evans, K. et al., *Arch. Ophthalmol.* 113:195-201, 1995; Freund, C. L. et al., *Cell* 91:543-553, 1997; Freund, C. L. et al., *Nat. Genet.* 18:311-312, 1998; Gregory, C. Y. et al., *Am. J. Hum. Genet.* 55:1061-1063, 1994; Li, X. et al., *Proc. Natl. Acad. Sci USA* 95:1876-1881, 1998; Sohocki, M. M. et al., *Am. J. Hum. Genet.* 63:1307-1315, 1998; Swain, P. K. et al., *Neuron* 19:1329-1336, 1987; Swaroop, A. et al., *Hum. Mol. Genet.* In press, 1999); 22q12.1-q13.2, for dominant Sorsby's fundus dystrophy, tissue inhibitors of metalloproteases-3 (TIMP3) (Felbor, U. et al., *Hum. Mol. Genet.* 4:2415-2416, 1995; Felbor, U. et al., *Am. J. Hum.*

Genet. 60:57-62, 1997; Jacobson, S. E. et al., *Nat. Genet.* 11:27-32, 1995; Peters, A. et al., *Retina* 15:480-485, 1995; Stöhr, H. et al., *Genome Res.* 5:483-487, 1995; Weber, B. H. F. et al., *Nat. Genet.* 8:352-355, 1994; Weber, B. H. F. et al., *Nat. Genet.* 7:158-161, 1994; Wijesvriya, S. D. et al., *Genome Res.* 6:92-101, 1996); and Xp11.4, for X-linked cone dystrophy (Bartley, J. et al., *Cytogenet. Cell. Genet.* 51:959, 1989; Bergen, A. A. B. et al., *Genomics* 18:463-464, 1993; Dash-Modi, A. et al., *Invest. Ophthalmol. Vis. Sci.* 37:998, 1996; Hong, H.-K., *Am. J. Hum. Genet.* 55:1173-1181, 1994; Meire, F. M. et al., *Br. J. Ophthalmol.* 78:103-108, 1994; Seymour, A. B. et al., *Am. J. Hum. Genet.* 62:122-129, 1998), the teachings of which are incorporated herein by reference. In addition, the world wide web site <http://WWW.SPH.UTH.TMC.EDU/RETNET/disease.htm> lists genetic polymorphisms for macular degeneration and for additional retinal degenerations that also may be associated with macular degeneration. However, none of the above genes or polymorphisms has been found to be responsible for a significant fraction of typical late-onset macular degeneration.

Two principal clinical manifestations of AMD have been described, both of which can occur in the same patient (Green and Key, 1977). They are referred to as the dry, or atrophic, form, and the wet, or exudative, form (Sarks and Sarks, 1989; Elman and Fine, 1989; Kincaid, 1992). In the dry form, the RPE and retina degenerate without coincident neovascularization. The region of atrophy that results is referred to as geographic atrophy. While atrophic AMD is typically considered less severe than the exudative form because its onset is less sudden, no treatment is effective at halting or slowing its progression. In the less common, but more devastating, exudative form, neovascular "membranes" derived from the choroidal vasculature invade Bruch's membrane, leak, and often cause detachments of the RPE and/or the neural retina (Elman and Fine, 1989). This event can occur over a short period of time and can lead to rapid and permanent loss of central vision. If one eye is affected, there is a high degree of probability that the second eye will develop a choroidal neovascular membrane within five years of the initial event (Macular Photocoagulation Study, 1977). Important clinical signs of neovascular AMD include gray-green neovascular membranes, dome-shaped RPE detachments, and disciform scars (caused by proliferation of fibroblasts and retinal glial cells) which are best visualized by their hyperfluorescence on fluorescein angiography (Elman and Fine, 1989).

Histopathologic studies have documented significant and widespread abnormalities in the extracellular matrices associated with the RPE, choroid, and photoreceptors of aged individuals and of those with clinically-diagnosed AMD (Sarks, 1976; Sarks, et al., 1988; Bird, 1992a; van der Schaft, et al., 1992; Green and Enger, 1993; Feeney-Burns and Ellersieck, 1985; Young, 1987; Kincaid, 1992). The most prominent extracellular matrix (ECM) abnormality is drusen,

deposits that accumulate ^{between} the RPE basal lamina and the ^{inner collagenous} layer of Bruch's membrane (Figure 1). Drusen appear to affect vision prior to the loss of visual acuity; changes in color contrast sensitivity (Frennesson, et al., 1995; Holz, et al., 1995b; Midena, et al., 1994; Stangos, et al., 1995; Tolentino, et al., 1994), macular recovery function, central visual field sensitivity, and spatiotemporal contrast sensitivity (Midena, et al., 1997) have been reported.

Drusen also cause a lateral stretching of the RPE monolayer and physical displacement of the RPE from its immediate vascular supply, the choriocapillaris. This displacement creates a physical barrier that may impede normal metabolite and waste diffusion between the choriocapillaris and the retina. It is likely that wastes may be concentrated near the RPE and that the diffusion of oxygen, glucose, and other nutritive or regulatory serum-associated molecules required to maintain the health of the retina and RPE are inhibited. It has also been suggested that drusen perturb photoreceptor cell function by placing pressure on rods and cones (Rones, 1937) and/or by distorting photoreceptor cell alignment (Kincaid, 1992).

A number of studies have demonstrated that the presence of macular drusen is a strong risk factor for the development of both atrophic and neovascular AMD (Gass, 1973; Lovie-Kitchin and Bowman, 1985; Lewis, et al., 1986; Sarks, 1980; Sarks, 1982; Small, et al., 1976; Sarks, et al., 1985; Vinding, 1990; Bressler, et al., 1994; Bressler, et al., 1990; Macular Photocoagulation Study). Pauleikhoff, et al. (1990) demonstrated that the size, number, density and extent of confluency of drusen are important determinants of the risk of AMD. The risk of developing neovascular complications in patients with bilateral drusen has been estimated at 3-4% per year (Mimoun, et al., 1990). A recent report from the Macular Photocoagulation Study Group shows a relative risk of 2.1 for developing choroidal neovascularization in eyes possessing 5 or more drusen, and a risk of 1.5 in eyes with one or more large drusen (Macular Photocoagulation Study, 1997). The correlation between drusen and AMD is significant enough that many investigators and clinicians refer to the presence of soft drusen in the macula, in the absence of vision loss, as "early AMD" (Midena, et al., 1997; Tolentino, et al., 1994), or "early age-related maculopathy" (Bird, et al., 1995). In addition to macular drusen, Lewis et al. (1986) found that the degree of extramacular drusen is also a significant risk factor for the development of AMD. A few clinical studies have shown that drusen regress and that visual acuity improves in some cases, following laser photocoagulation (Sigelman, 1991; Little, et al., 1997; Figueroa, et al., 1994; Frenneson and Nilsson, 1996). While prophylactic laser treatment may be helpful for some patients (Little, et al., 1997), it appears that other patients react adversely to laser treatment of the macula (Hyver, et al., 1997). In addition, while there may be long term benefits

for the patient following ^{photocoagulation} ~~coagulation~~, these may not be worth ^{the loss} ~~loss~~ of vision frequently associated with this procedure.

The terminology most commonly used to distinguish drusen phenotypes is hard and soft (see, for example, Eagle, 1984; Lewis, et al., 1986; Yanoff and Fine, 1992; Newsome, et al., 1987; Mimoun, et al., 1990; van der Schaft, et al., 1992; Spraul and Grossniklaus, 1997), although numerous phenotypes exist (Mullins and Hageman, Mol.Vis., 1999). Hard drusen are small distinct deposits comprised of homogeneous eosinophilic material. Histologically, they are round or hemispherical, without sloped borders. Soft drusen are larger and have sloped, indistinct borders. Unlike hard drusen, soft drusen are not usually homogeneous, and typically contain inclusions and spherical profiles. An eye with many large/soft drusen is at a significantly higher risk of developing complications of AMD than is an eye with no drusen or a few, small drusen. The term "diffuse drusen," or "basal linear deposit," is used to describe the amorphous material which forms a layer between the inner collagenous layer of Bruch's membrane and the RPE. This material can appear similar to soft drusen histologically, with the exception that it is not mounded.

Our knowledge of drusen composition, especially as it relates to phenotype, is scant. Wolter and Falls (1962) observed that drusen stain with oil red O, indicating the presence of neutral lipids in at least some drusen. Pauleikhoff, et al. (1992) used lipid-based histochemical staining approaches to show that different phenotypes of drusen contain either phospholipids or neutral lipids. These "hydrophilic" drusen were also bound by an anti-fibronectin antibody. Pauleikhoff et al. (1992) concluded that phospholipid-containing, but not neutral lipid-containing, drusen were anti-fibronectin antibody-reactive. Other investigators have not been able to reproduce the observation of an association of fibronectin with drusen (van der Schaft, et al., 1993; Mullins et al., 1999). These data suggest that drusen are either hydrophobic or hydrophilic, and that different drusen classes may indicate significantly different pathologies, suggesting the existence of different compositional classes of drusen, not solely based on morphology (i.e., hard and soft).

Farkas, et al. (1971b) analyzed drusen composition by enzymatic digestion, organic extraction, and histochemical staining methods for carbohydrates and other molecules. They concluded that drusen are comprised of sialomucins (glycoproteins with O-glycosidically-linked oligosaccharides) and cerebroside and/or gangliosides.

Newsome et al. (1987) described labeling of soft drusen with antibodies directed against fibronectin, and to hard and soft drusen with antibodies directed against IgG and IgM. In addition, weak labeling of drusen with antibodies directed against beta amyloid (Loeffler, et al.,

1995) and complement factors (C1q, C3c, C3d, and C4) (van der Schoot et al., 1993), and more intense labeling with antibodies directed against ubiquitin (Loeffler and Mangini, 1997) and TIMP-3 (Fariss, et al., 1997), has been reported. Antibodies to other ECM molecules, including collagen types I, III, IV, and V, laminin, and heparan sulfate proteoglycan, have also been reported as being components of drusen in "diffuse, mottled or superficial laminar" patterns (Newsome, et al., 1987).

Discrepancies between the results of the immunohistochemical studies described above are likely due to disagreement upon a universal classification system for drusen, the use of dehydrated, paraffin-embedded tissues (which potentially resulting in the extraction of some drusen constituents) as opposed to frozen sections, and the use of antibodies directed against different epitopes of the same protein. Additionally, the use of tissues that are fixed or frozen within a short period after death reduces false negatives (due to post-mortem autolysis and loss of antigenicity) and false positives (due to post-mortem diffusion and loss of physiologic barriers).

In addition to the lipid, protein and carbohydrate composition of drusen, several investigators have identified plasma membrane or cellular organelles in drusen. Farkas et al. (1971a) described the presence of numerous degenerating organelles in drusen, including what appeared to be lysosomes. Based on the observation that similar material was present on the RPE side of Bruch's membrane prior to drusen formation, they suggested that drusen constituents were derived from the RPE. However, lysosomal enzyme activity within drusen has not been verified (Feeney-Burns, et al., 1987). Burns and Feeney-Burns (1980) described the presence of "cytoplasmic debris" in small drusen, which they inferred was derived from the RPE. Feeney-Burns and Ellersieck (1985) later described a paucity of debris in Bruch's membrane directly beneath drusen, and suggested that drusen may result from an inability of the choroid to clear debris from sites of drusen deposition. Drusen contain a number of drusen-associated markers (DRAMs), including amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, β 2 microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin or vitronectin.

A comprehensive understanding of drusen biogenesis is lacking. At least twelve pathways for drusen genesis have been suggested in the literature (Duke-Elder and Dobree, 1967; Wolter and Falls, 1962; Ishibashi, et al., 1986a). These fall into two general categories based on whether drusen are derived from the RPE or the choroid. Theories related to the derivation of drusen from RPE cells include the concepts that: drusen result from secretion of

derived from

deposition theories

abnormal material ~~derived~~ from RPE or photoreceptors ("~~deposition~~"--Muller, 1856; Ishibashi, et al., 1986; Young, 1987); transformation of degenerating RPE cells into drusen ("transformation theories"--Donders, 1854; Rones, 1937; Fine, 1981; El Baba, et al., 1986) or some combination of these pathways. Specifically, some investigators have concluded, based on ultrastructural data, that drusen are formed when the RPE expels its basal cytoplasm into Bruch's membrane (Ishibashi, et al., 1986a), possibly as a mechanism for removing damaged cytosol (Burns and Feeney Burns, 1980). However, very few convincing images of this process have been demonstrated. Others have postulated that drusen are formed by autolysis of the RPE, due to aberrant lysosomal enzyme activity (Farkas, et al., 1971a), although more recent enzyme histochemical studies have failed to demonstrate the presence of lysosomal enzymes in drusen (Feeney-Burns, et al., 1987). Other mechanisms, including lipoidal degeneration of the RPE (Fine, 1981) and a derivation from vascular sources (Friedman, et al., 1963) have also been postulated (summarized in Duke-Elder and Dobree, 1967).

Duvall et al. (1985) suggested a role for choroidal pericytes in keeping Bruch's membrane clear of debris. They suggested that dysfunction of pericytes leads to the formation of drusen, either by the accumulation of material from the choroid or by the failure to remove material deposited by the RPE.

Killingsworth et al. (1990) described macrophages participating in the breakdown of Bruch's membrane in the neovascular stage of AMD and in drusen regression, and show one electron micrograph depicting structures resembling drusen cores. Duvall and Tso (1985) showed choroidal macrophages in the region of the Bruch's membrane are involved in the removal of drusen in monkey eyes, following laser photocoagulation. Penfold and others (Penfold et al., 1985; Penfold et al., 1986; Oppenheim and Leonard, 1989) provided "circumstantial evidence . . . for the involvement of (choroidal) leukocytes, in the promotion of neovascular proliferation." However, these data were restricted to morphological observations only. Based on those observations investigators suggested that macrophages participate in the neovascularization stage of drusen formation.

Changes related to AMD that are observed in the fundus may vary with different AMD phenotypes. At least ten distinct AMD fundus patterns have been identified at the University of Iowa that may be termed "The University of Iowa AMD/Drusen Classification." Certain fundus patterns may correlate with particular arterial wall disruptive disorders; for example, a certain pattern may be identified that correlates with an increased likelihood of developing a AAA or of having expansion occur in an established AAA, while other fundus patterns may be indicative of an increased likelihood of developing a TAAA or a dissecting TAA. The different fundus

different forms disorders, may
patterns, like the ~~different forms~~ of arterial wall disruptive ~~disorder~~ ~~may~~ correlate with different underlying genetic patterns.

4.2a(ii) Working Hypothesis of Drusen Biogenesis

5 Proposed herein is a unifying theory of drusen biogenesis that attempts to incorporate a large body of new and previously published data generated in this, and other, laboratories. This theory is put forth with the acknowledgment that numerous AMD genotypes may exist. Thus, only some aspects of the proposed hypothesis may be involved in any given AMD genotype. Importantly, the theory is based upon novel data generated in this laboratory documenting that
10 dendritic cells are associated with drusen. This observation invokes, for the first time, the potential for a direct role of cell-mediated processes in drusen biogenesis. Thus, we believe that any working hypothesis pertaining to drusen biogenesis and the etiology of drusen associated ocular diseases must include a role for dendritic cells.

15 The presence of dendritic cells in inflammatory lesions is well-recognized. It is clear that dendritic cells must be recruited, activated, and migrate to, sites of inflammation, rather than passively migrating to these sites. Dendritic cells are typically recruited to sites of tissue damage by various chemoattractants, heat shock proteins, DNA fragments, and others. Choroidal dendritic cell processes are associated with the smallest of drusen, and are often observed in the sub-RPE space in association with whole, or portions of, RPE cells that have been shunted into
20 Bruch's membrane, prior to the time that drusen, *per se*, are detectable. Based on these observations, proposed herein is a mechanism in which choroidal dendritic cells are activated and recruited by locally damaged and/or sublethally injured RPE cells. This idea is consistent with recent data showing that dendritic cells, and thus the innate immune system, can be activated by microenvironmental tissue damage. In this state, these cells extend a cellular process through
25 Bruch's membrane in order to gain access to the site of tissue damage. In this role, choroidal dendritic cells may thus serve as sentinel receptors with the capacity to respond to local cell injury, and ultimately provide for the overall integration of immune-mediated processes that determine the outcome of the overall response.

30 In this model, the injured RPE itself (by whatever mechanism this occurs) may serve as a source of soluble cytokines or other stimulatory factors that initiate dendritic cell recruitment and activation. The data presented herein clearly supports accelerated RPE cell death in eyes derived from donors with AMD, as compared to age-matched controls. Based on available information from other systems, and upon previous suggestions pertaining to the etiology of AMD, RPE cell death might occur by several mechanisms, including ischemia, necrosis, gene-mediated injury,

induced dysfunction

or systemic

Bruch's membrane-induced dysfunction, oxidative injury from light systemic factors (e.g. smoking-generated compounds), lipofuscin accumulation, or autoimmune phenomena, to list a few. Based on existing data, it is likely that RPE cell death would most likely have to be due to necrosis, rather than to apoptosis, since cells undergoing apoptotic cell death do not recruit dendritic cells. Indeed, the data provides compelling evidence for an absence of apoptotic RPE cell death in human donor eyes.

Several known pathways can initiate receptor-ligand interactions between dendritic cell precursors and injured tissue. These include cytokines such as IL-1, IL-6, IL-12, TNF-alpha, and GM-CSF, heat shock proteins, altered expression of cell surface proteins and DNA in the presence of free radicals. The novel observation of clonal expression of HLA-DR, CD68, vitronectin, S-100, clusterin, and apolipoprotein E by RPE cells in eyes from donors with drusen may be particularly significant in this respect. Furthermore, up-regulation of various cell death- and immune-associated molecules by the RPE/choroid in eyes with developing drusen and AMD have been identified using differential display and gene array analyses. In addition, there is evidence that free radicals, which are known to be present in high concentrations at the RPE-retina-choroid interface, might be immunostimulatory. There is also data suggesting that ceroid (a potential component of lipofuscin) derived from necrotic cells may serve as an antigen in the generation of certain autoimmune diseases. This could explain the general contention that oxidative stress and/or lipofuscin may lead to RPE dysfunction and the development of AMD (Mainster, M.A., *Light and macular degeneration: a biophysical and clinical perspective*. Eye, 1987. 1(Pt 2): p. 304-10).

Once inside the lesion (a.k.a. the drusen), dendritic cells might then contribute to the chronicity (induced chronic inflammatory lesions) of AMD by any number of mechanisms, including immune complex formation, complement activation, and/or *in situ* activation of choroidal T-cells, other phagocytic cells, and matrix proteolysis. The presence of numerous immune-associated constituents in drusen, including immunoglobulins, complement proteins, and some acute phase proteins, could be explained by such an event. One might predict that the dendritic cell response would be down-regulated once the local tissue damage has been repaired, thus restoring tolerance. This type of self-limiting control is typically accomplished in other systems via turnover of dendritic cells; the influx of new dendritic cell precursors and the concomitant reduction in the influx of mature dendritic cells into the lymph nodes is typically sufficient to shift the balance back to tolerance. In other cases, natural killer cells recognize mature dendritic cells as targets, providing a negative feedback effect on antigen presentation, forcing the system into tolerance. However, in the case of AMD, we suggest that a state of

chronic inflammation ^{persists for} ~~per~~ for many years. In this scenario, ^{cyclical events} ~~cyclic~~ events of RPE cell death may occur over a period of many years that do not allow the system to return to tolerance. In one example, this might occur as a result of genetic preprogramming, as in the case of a RPE gene mutation. In another example, local activation of complement and HLA-DR expression by RPE cells, initiated by dendritic cells recruited to the sub-RPE region, might lead to clonal RPE cell death, thereby maintaining a state of chronic inflammation. Other scenarios can certainly be envisioned and must be tested. A negative outcome of this entire process may be that Bruch's membrane and the surrounding extracellular matrix may be degraded, angiogenic factors may be generated, resulting in opportunistic neovascularization of the sub-RPE and subretinal spaces. Although there is little information in the literature concerning matrix-degrading enzyme expression by dendritic cells. However, MT-1-MMP expression within drusen cores has been observed, suggesting a possible mechanism for DC-mediated matrix breakdown.

The notion that dendritic cells may be activated by local tissue injury might also initiate an autoimmune response to retinal and/or RPE antigens that are uncovered during tissue damage. The availability and amount of RPE debris/antigen will most likely determine which ensuing pathway is involved. Such autoimmune responses have been documented as a consequence of ischemia or injury to the heart and we have recently identified autoantibodies in the sera of individuals with AMD that are directed against retinal and RPE proteins of 35kDa and 53kDa. This might occur as a consequence of aberrant delayed-type hypersensitivity responses, perhaps explaining the presence of serum autoantibodies in at least some AMD patients. It is also conceivable that the groundwork for this process is primed earlier in life by necrosis of RPE cells, potentially explaining the consequence of the wave of peripheral RPE cell dropout we have observed in the second and third decades of life in preliminary studies.

In the model presented herein, the initiating RPE injury event is followed by the continued deposition of drusen-associated constituents. Early DRAM-matrix complexes, such as immune complexes, or other local ligands might serve as "nucleation sites" for the deposition of additional self-aggregating proteins and/or lipids. These constituents could be derived from either the plasma and/or local cellular sources. Based on the knowledge that many DRAMs are circulating plasma proteins, it is plausible that some DRAMs pass out of choroidal vessels and into the extracellular space adjacent to the RPE where they bind to one or more ligands associated with Bruch's membrane in the aging eye. These ligands could be basement membrane components, plasma membrane receptors, secretory products derived from RPE or choroidal cells, or byproducts of cellular autolysis. As reported herein, a number of drusen-associated molecules, including apolipoprotein E, vitronectin, fibrinogen, C reactive protein, and

transferrin, have been synthesized by the RPE and/or retina. Although unexpected, these data support the concept that some DRAMs may be synthesized and secreted locally. It remains to be determined whether up- or down-regulation of DRAM synthesis by local cells correlates with drusen deposition and/or AMD. As these abnormal deposits increase in size they displace the RPE monolayer and are recognized clinically as drusen.

This model might also predict an imbalance in extracellular matrix synthesis, degradation, and/or turnover, thereby leading to events such as choroidal neovascularization, a hallmark characteristic of some forms of AMD, cellular proliferation, cellular differentiation, and interstitial fibrosis. In many organs, fibrogenesis is a common complication of tissue injury, independent of the initial site of said injury. The recruitment of immune cells, and their activation and/or modulation by resident cells, represents a key step in the cascade of events that ultimately lead to fibrosis. Recent studies also suggest that distinct functional fibroblast phenotypes may play a central role in early fibrosis, including the recruitment of immune cells.

Choroidal fibrosis has been documented in a subset of donor eyes. There is a significant correlation between choroidal fibrosis and age. Furthermore, preliminary data suggest that there is a strong correlation between choroidal fibrosis and AMD, aortic aneurysms, aortic stenosis, and possibly COPD. These choroids are characterized ultrastructurally by massive accumulations of newly synthesized collagen and elastin fibrils, as well as filamentous collagens and microfilaments, that fill the normally loosely packed choroidal stromas. The major collagen fibrils average 0.042-0.063 μm in diameter as compared to the fibrillar collagen in the sclera, which averages 0.211-0.253 μm in diameter. Furthermore, the collagen fibrils in these donors exhibit a classic spiraled morphology in longitudinal and cross sections. It is thought that spiraled collagen results from disaggregation of fibrils and/or to incorporation of uncleaved procollagen molecules. This collagen phenotype is observed in a few heritable connective tissue diseases (Ehler's-Danlos; PXE; dermatoparaxis), as well as in other conditions (collagenofibrotic glomerulopathy, scleroderma, atherosclerosis, amyloid, emphysema, atheromatous plaques). Clear indications of active elastin synthesis (including dilated RER, pockets of microfilaments, and elastin exhibiting the morphological characteristics of newly synthesized protein) are also observed along attenuated fibroblast cell processes and interspersed amongst the collagen fibrils.

A hypothetical pathogenic sequence of events consistent with known data is: 1) RPE dysfunction (e.g., precipitated by an inherited susceptibility and/or environmental exposure); 2) accumulation of intracellular material in the RPE (e.g., accumulation of normal substrate material that is not enzymatically degraded properly vs. abnormal substrate material); 3) abnormal accumulation of extracellular material (basal laminar and basal linear deposit); 4)

change in Bruch's ^{membrane} composition (e.g., increased lipid ^{deposition} and protein crosslinking); 5) change in Bruch's membrane permeability to nutrients (e.g., impaired diffusion of water soluble plasma constituents across Bruch's membrane); and 6) response of the RPE to metabolic distress (i.e., atrophy vs. CNV growth). Histopathological and clinical studies indicate that areas of choroidal ischemia often are seen near CNVs in AMD patients. In response to decreased oxygen delivery/metabolic "distress", the RPE may elaborate substances leading to CNV growth. Perhaps RPE atrophy, followed by choriocapillaris and photoreceptor atrophy, is a response to decreased nutrients/increasing metabolic abnormalities in areas of excessive accumulation of extracellular debris. Unanswered questions regarding AMD include: 1) is AMD an ocular manifestation of a systemic disease or purely an ocular disease?; 2) what determines whether CNVs vs. atrophy of the RPE-choriocapillaris-photoreceptors develops?; and 3) what induces the maturation of CNVs into an inactive scar, and what limits the growth of most CNVs to the area centralis?

Since drusen share a number of molecular constituents in common with abnormal deposits associated with a variety of other age-related diseases, drusen may represent an ocular manifestation of amyloidosis, elastosis, dense deposit disease, and/or atherosclerosis. Although modulated by different genes and/or environmental influences, all these diseases give rise to similar yet distinguishable pathological phenotypes by triggering a similar set of biological responses that include inflammation, coagulation, and activation of the immune system. Thus, the invention provides a valuable recognition of these similarities as compared to other age-related diseases which manifest themselves in deposits or plaques.

4.2b: Arterial Wall Disruptive Disorders

Arterial wall disruptive disorders may affect the abdominal aorta, resulting in the formation of abdominal aortic aneurysm (AAA). AAA are a form of arterial wall disruptive disorders entailing aneurysm formation in the aortic wall that is localized within the abdomen. AAA are therefore a form of aortic wall disruptive disorders. These lesions are becoming increasingly common in developed countries including the United States, Australia, and Europe. (MacSweeney et al., *Brit J. Surg.* 81:935-941, 1994). The prevalence of AAA is approximately 6% (2-9%) in the general population and primarily affects individuals over the age of about 65. (Wilmink, A.B. and Quick, C.R., *Brit. J. Sur.*, 85:152-162, 1998). Because the size of the population over the age of 65 continues to increase, AAA and other arterial wall disruptive diseases will likely place a great burden on health resources in the near future.

Aortic wall disruptive disorder also includes aneurysms of the thoracic aorta.

generally have diaphragm
These aneurysms generally have a component extending below the diaphragm, so are more accurately termed thoracoabdominal aortic aneurysms (TAAA). They are classified according to their anatomic extent. (Crawford ES et al., "Thoracoabdominal aortic aneurysms: preoperative and intraoperative factors determining immediate and long-term results of operations in 605 patients," J. Vasc. Surg. 3:389-404, 1986). Thoracic aortic aneurysms without dissection may be caused by a number of factors, including atherosclerotic medial degenerative disease, congenital disorders such as Marfan's and Ehlers-Danlos syndromes, mycotic lesions and Takayasu's aortitis. Aortic wall disruptive disease further includes aortic dissections, whether or not they are associated with aneurysm formation. Atherosclerotic medial degenerative disease (82%) and dissection (17%) are responsible for over 95% of all TAAA. (Panneton JM et al., "Nondissecting thoracoabdominal aortic aneurysms: Part I," Vasc. Surg. 9:503-514, 1995). Hypertension is commonly found in both groups of TAAA patients. Patients with degenerative (atherosclerotic) aneurysms, however, tend to have a higher incidence of coronary artery disease, chronic renal insufficiency, cerebrovascular disease and peripheral vascular disease.

While it is understood herein that the systems, methods and kits of the present invention are related to arterial well disruptive disorders in all anatomic locations, the present invention will be illustrated with particular reference to the disruptive disorder of the aortic wall that culminates in AAA or in TAAA.

4.2b(i) *Anatomy of the Arterial Wall*

Arteries are divided into three general categories based on the anatomy of their walls: large elastic arteries, medium muscular arteries and small arteries. All arteries possess three layers, the intima, the media and the adventitia. The media, bounded by the internal and the external elastic laminae, contains smooth muscle cells embedded in a matrix of collagen, elastin and proteoglycans. The adventitia, lying outside the external elastic lamina, is composed of loose connective tissues, fibroblasts, capillaries, leukocytes and small nerve fibers. The arterial wall is nourished by a system of blood vessels called vasa vasorum.

The large elastic arteries of the body include the aorta and its major branches. The medium muscular arteries include most of the distributing vessels to the organs. These two classes of arteries differ primarily in the amount of elastic tissue present in the media. In the aortic wall there are well-defined lamellar units consisting of commonly oriented and elongated smooth muscle cells and their surrounding matrix. The matrix includes a meshwork of collagen and a layer of elastin. (Clark JM et al., "Transmural organization of the arterial media: the lamellar unit revisited," Arteriosclerosis 5:19, 1985). The lamellar unit represents the structural

the aortic layers
and functional unit of the aortic wall. The lamellar unit consists of layers of smooth muscle cells interspersed with clearly defined lamellae of elastin. Tropoelastin monomers are normally produced by fibroblasts and vascular smooth muscle cells (SMCs) and deposited onto a microfibrillar network of fibrillin and other proteins, and cross-linked by lysyl oxidase to form mature elastic fibers, which are arranged in concentric lamellae.

4.2b(ii) Genetics of AAA

A familial tendency to develop aneurysms is well documented in about 15-20% of patients with AAA, suggesting a genetic predisposition to AAA in some patients, a positive family history in a first-degree relative being a significant risk factor for developing AAA. (MacSweeney et al., *Brit J. Surg.* 81:935-941, 1994). The most likely explanation for the occurrence of AAA in families is a single gene showing dominant inheritance and low penetrance. (Verloes, A., et al., *J. Vasc. Surg.* 21:646-655, 1995). Familial associations for other aneurysms have also been noted. (Kojima M, et al., "Asymptomatic familial cerebral aneurysms", *Neurosurgery*, 43(4):776-81 1998 Oct). Familial clustering has been observed for inflammatory aneurysms, correlated with the identification of an HLA-DR B1 allele in a cohort of those patients. (Rasmussen TE, et al., "Genetic risk factors in inflammatory abdominal aneurysms: polymorphic residue 70 in the HLA-DR B1 gene as a key genetic element," *J Vasc Surg*, 25(2):356-64 1997 Feb). Genetic factors have been associated with development of other aneurysmal syndromes, in one case associating a fibrillin genotype, blood pressure and aneurysm formation. (Powell JT, et al., "Interaction between fibrillin genotype and blood pressure and the develop aneurysmal disease," *Ann NY Acad Sci*, 800(-HD-):198-207 1996 Nov 18).

Attempts to define the genetic component(s) underlying AAA have used a variety of strategies, including both linkage analysis and candidate gene approaches. Several candidate genes for AAA, including collagen, $\alpha 1$ - antitrypsin, fibulin-2 (Kuivaniemi et al., *Eur. J. Hum. Gen* 6:642-646, 1999), proteolytic enzymes, tissue inhibitors of metalloproteases (TIMPs) and haptoglobin have been investigated to explain the familial clustering of AAA. Significantly, polymorphisms in the elastin gene have not been demonstrated in patients with AAA. Genetic mutations in fibrillin-1 and type III procollagen have been found to be responsible for aneurysm development in a small number of patients (e.g., in Marfan's syndrome and Ehler- Danlos syndrome, respectively). A mutant gene for the alpha chain of type III collagen co-segregates with aneurysmal disease in 3 out of 50 families, and a single base mutation at position 619 in collagen type III has been described in one family. (Kontusaari, S. et al., *Ann. N.Y. Acad. Sci.*, 580:556-557, 1990). About 2% of aortic aneurysms are thought to be caused by a gly136-to-arg

mutation in the type III procollagen gene. (Tromp, G. et al., *J. Clin. Invest.*, 91:2539-2545). A deficiency allele for α 1-antitrypsin was found in 5 out of 47 patients and a nucleotide substitution for TIMP(1) was found in 2 out of 6 patients. A mutation in the COL3A1 gene has been implicated in the pathogenesis of some familial aortic aneurysms. (Reviewed in Kuivaniemi, H. et al., *J. Clin. Invest.* 88:1441-1444, 1991). The MZ- α 1-antitrypsin phenotype has been found with increased frequencies in individuals with AAA. (Cohen, J. R. et al., *J. Surg. Res.* 49:319-321, 1990). Another study suggested that AAA may be associated with the 2-1 and 1-1 genotypes of haptoglobin. (Norrgard, O., *Hum. Hered.* 34:166-169, 1984). Taken together, available data suggest that, while AAA may be inherited in many cases, the gene or genes responsible for most cases of AAA remain to be identified.

4.2b(iii) Other AAA Risk Factors

Aside from the undefined genetic component, the etiology of AAA is currently thought to arise through a complex interaction among various risk factors including atherosclerosis, aging, autoimmune processes, gender, race, cigarette smoking and hypertension. Severe intimal atherosclerosis is almost invariably found in AAA at the time of surgery or postmortem examination, and patients with atherosclerosis in other circulatory beds have an increased prevalence of AAA. However, unlike atherosclerosis, AAA is dominated primarily by degenerative changes in the elastic media, displays different epidemiological characteristics and has different genetic risk factors. Thus, AAA is thought to arise through pathophysiologic processes that are distinct from occlusive atherosclerosis, and that aortic atherosclerosis is neither sufficient, nor even necessary, for aneurysm development. Indeed, some evidence has suggested that arterial wall remodeling associated with the regression of atherosclerotic plaques might be linked to aneurysm development. Current dogma would indicate that AAA arises from pathophysiologic processes that are distinct from occlusive atherosclerosis, even though certain studies have pointed to their overlap. (Robert L, et al., "Elastin-elastase-atherosclerosis revisited," *Atherosclerosis*, 140(2):281-95 1998 Oct).

Male gender is also considered a risk factor for AAA, with some studies showing male:female ratios as high as 9:1. The possibility that there might be a relative biological resistance to the development of aneurysm in women suggests a sex-linked genetic component. For reasons that are not yet clear, there also appears to be a predilection for aortic aneurysms in Caucasians as compared to non-Caucasian populations.

There is also a strong association between persistent cigarette smoking and AAA, with a time lag of approximately 40 years. (MacSweeney et al., *Brit J. Surg.* 81:935-941, 1994). Some

suggested that tar may
investigators have suggested that a component of smoke other than tar may contribute to the disease. (MacSweeney, et al., *supra*). For example, it has been proposed that increased levels of serum cotinine may contribute to the inactivation of α 1-antitrypsin, which may subsequently enhance the degradation of the aortic wall by proteolytic enzymes, contributing to aneurysmal dilatation. Interestingly, the incidence of emphysema/COPD is high in patients with AAA, suggesting that the inactivation of α 1-antitrypsin in these patients further disrupts the production of elastin need for maintenance of the aortic lumen. (Nicholls SC, et al., "Rupture in small abdominal aortic aneurysms," J Vasc Surg, 28(5):884-8 1998 Nov).

Hypertension is also considered a significant risk factor for AAA. It is associated with both increased prevalence and an increased risk of rupture. Though the risk of rupture of a <3cm aneurysm with a diastolic pressure of less than 75mm Hg is only 2%, the risk of rupture can increase to 100% for a 5cm aneurysm and a diastolic pressure higher than 105mmHg. (Schwartz, S. I., *supra* at 942).

4.2b(iv) AAA Pathogenesis

The pathogenesis of AAA involves the complex interaction of a variety of biological processes including marked alterations in elastin and collagen, chronic inflammation, autoimmune-associated processes, neovascularization, and a decrease in vascular smooth muscle cells (Thompson, RW, Current Opinion Cardiology 11:504-518, 1996). These processes act over many years and, ultimately, weaken the aortic wall. (Cenacchi G, et al., "The morphology of elastin in non-specific and inflammatory abdominal as aneurysms. A comparative transmission, scanning and immunoelectronmicroscopy study," J Submicrosc Cytol Pathol, 27(1):75-81 1995 Jan). Although it is clear that weakening of the aorta involves disruption of the balance between collagen and elastin, controversy surrounds the mechanisms involved and their relative importance. (Anidjar S, et al., "Experimental study of determinants of aneurysmal expansion of the abdomen," Ann Vasc Surg, 9(2):127-36 1994 Mar).

Quantitative analyses show that elastin compromises 35% of the dry weight of an normal aorta media, but only 8% of the aortic media of patients with aneurysms (Campa, JS, Atherosclerosis 65:13-21, 1987). Elastin in the adventitia may also be affected in AAA. (White JV, et al., "Adventitial elastolysis is a primary event in aneurysm formation," J Vasc Surg, 17(2):371-80; discussion 380-1 1993 Feb). The biomechanical effect of the alteration in aortic wall elastin is to increase the stiffness of the affected areas of the aorta, with predictable hemodynamic effects. (He CM, et al., "The composition and mechanical properties of abdominal aortic aneurysm," J Vasc Surg, 20(1):6-13 1994 Jul).

vascular tissues

muscle

In normal ~~vascular tissues~~, elastin is produced by smooth ~~muscle~~ cells, and probably by fibroblasts. Elastin, like collagen, is secreted from the producer cells as tropoelastin molecules that combine to form elastin fibrils. Certain factors associated with wound healing can increase the cellular production of elastin, e.g., TGF-beta. (Sauvage M, et al., "Localization of elastin mRNA and TGF-beta in rat aorta and caudal artery as a function of age," Cell Tissue Res. 29:305-314, 1998). Certain other factors, in particular inflammatory cytokines such as TNF, can adversely affect the production of elastin. (Kahari VM et al., TGF-beta up-regulates elastin gene expression in human skin fibroblasts: evidence for post-transcriptional modulation," Lab Invest 66:580-8, 1992) Elastogenesis and elastolysis ideally remain in a steady state.

A model for atherosclerosis has been proposed that focuses on the relationship between elastin breakdown and elastin production in the arterial wall. (Robert L, et al., "Elastin-elastase atherosclerosis revisited," Atherosclerosis 140:281-295, 1998) According to this model, age-related modifications of the vessel wall include upregulation of elastolytic enzymes. The progressive deposition of lipids in elastic tissues, as well as the addition of lipoproteins or lipids to cell or organ cultures have been shown to modify matrix biosynthesis and upregulate elastase expression. Furthermore, the elastin laminin receptor present on vascular smooth muscle cells has been shown to trigger NO dependent vasodilatation and downregulation of cholesterol synthesis in young subjects, functions that decrease or disappear with age. (Varga Z, et al., "Age-dependent changes of K-elastin stimulated effector functions of human phagocytic cells: relevance for atherogenesis," Exp Gerontol 32:653-62, 1997) These findings have also been extended to the T-lymphocytes present in the atherosclerotic plaque. Significantly, after vascular injury such as balloon angioplasty, both intimal and medial smooth muscle cells proliferate. (Strauss BH, et al., "Extracellular matrix remodeling after balloon angioplasty injury in a rabbit model of restenosis," Circ Res 75:650-8, 1994) In those vascular injuries associated with the processes of atherosclerosis, there is likewise a proliferation of both types of cells. Elastin synthesis and smooth muscle cell proliferation are thought to be tightly regulated during repair of arterial wall injury. (Aoyagi M, et al., "Smooth muscle cell proliferation, elastin formation, and tropoelastin transcripts during the development of intimal thickening in rabbit carotid arteries after endothelial denudation," Histochem Cell Biol 107:117, 1997)

Decrease in elastin content in the aortic wall, by whatever mechanism this occurs, is a key element in aneurysm formation. Not to be bound by theory, we are nonetheless aware of various mechanisms that have been proposed. (Minion DJ, et al., "Elastin is increased in abdominal aortic aneurysms," J Surg Res, 57(4):443-6 1994 Oct). In addition, elastin degradation products (EDPs) may contribute to the inflammatory processes that further degrade

43
example peptide
the aortic wall. For example, rats infused with EDPs, such as the peptide Val-Gly-Val-Ala-Pro-Gly, develop a weakened aorta and are chemotactic for dendritic cells and macrophages (Senior, R. M. et al., *J. Cell Biol.*, 99:870-874, 1984).

5 Numerous observations suggest that enzymatic degradation of elastin plays a critical role in the evolution of aneurysm disease. One type of elastase found in aneurysm walls has been associated with human macrophages. (Curci JA, et al., "Expression and localization of macrophage elastase matrix metalloprotein abdominal aortic aneurysms," *J Clin Invest*, 102(11):1900-10 1998 Dec 1). In fact, a number of proteolytic enzymes, including elastases, collagenases, and gelatinases are found in increased concentrations in the aortic media of patients
10 with AAA. (Brophy, CM et al., *J Surg Research* 50:653-657, 1991; Vine and Powell, *Clinical Sci.*, 81:233-239, 1991). In mycotic aneurysms, increases in elastase thought to originate from neutrophils have been identified in the arterial wall. (Buckmaster MJ, et al., "Source of elastin-degrading enzymes in mycotic aortic aneurysms: bacterial or inflammatory response?," *Cardiovasc Surg*, 71:16-26 1999 Jan). MMP2, MMP3 and MMP9, enzymes that have the
15 capability to degrade elastin, are expressed and produced in increased amounts in the aortas of humans with AAA. (Sakalihasan N, et al., "Activated forms of MMP2 and MMP9 in abdominal aortic aneurysms," *J Vasc Surg*, 24(1):127-33 1996 Jul.; Davis V, et al., "Matrix metalloproteinase-2 production and its binding to the matrix are in abdominal aortic aneurysms," *Arterioscler Thromb Vasc Biol*, 18(10):1625-33 1998 Oct). The association of MMP
20 overexpression with aneurysm formation has also been observed in a rat model. (Allaire E, et al., "Local overexpression of TIMP-1 prevents aortic aneurysm degeneration an a rat model," *J Clin Invest*, 102(7):1413-20 1998 Oct 1). Macrophages bearing MMP-9 have also been identified in temporal arteritis, raising the possibility that there is some similarity between the pathological processes at work in both conditions. (Nikkari ST, et al., "Macrophages contain 92-kd gelatinase
25 (MMP-9) at the site of degenerated elastic lamina in temporal arteritis," *Am J Pathol*, 149(5):1427-33 1996 Nov).

Recent studies have suggested that increased elastase activity is more likely to be a primary event than a response to aneurysm formation (Cohen JR et al. *Annals Vascular Surgery* 4:570-574, 1990). Changes in elastin composition have been observed in dissecting thoracic
30 aneurysms, possibly associating this mechanism with tendency for dissections to rupture. (Cattell MA, et al., "Increased elastin content and decreased elastin concentration may be predictive factors in dissecting aneurysms of human thoracic aorta," *Cardiovasc Res*, 27(2):176-81 1993 Feb). Plasmin, which is capable of destroying the extracellular matrix directly and indirectly via activation of latent MMPs, is also elevated in AAA tissues. Decreased activity of TIMPs has

genetic basis sequencing
been suggested as a genetic basis underlying AAA, although DNA sequencing has provided no evidence to support this claim. (Tamarina NA, et al., "Expression of matrix metalloproteinases and their inhibitors in aneurysms of the aorta," *Surgery*, 122(2):264-71; discussion 271-2 1997 Aug; Elmore JR, et al., "Expression of matrix metalloproteinases and TIMPs in human abdominal aneurysms," *Ann Vasc Surg*, 12(3):221-8 1998 May).

Although factors that result in fragmentation of elastin may be important in the etiology of AAA, factors regulating the balance of collagen synthesis and degradation may also determine the rate of AAA progression. (Halloran, B.G. and Baxter, B.T., *Sem. Vasc. Surg.* 8:85-92, 1995). Early studies suggested that collagen comprises an increased proportion of the dry weight of the aortic media in patients with AAA, though other studies suggest the normal human abdominal aortic wall and that of patients with AAA contain similar amounts of collagen, as well as similar ratios between collagen types. (Menashi, S., *J. Vasc. Surg.*, 578-582, 1987). However, the solubility of collagen in the aneurysmal wall and its susceptibility to EDTA-induced dissociation are distinctly decreased in AAA. (Sobolewski, K. et al., *Act. Biocim. Polonica*, 42:301-308, 1995). Moreover, collagen turnover is increased in AAA, as determined, for example, by the concentration of the amino terminal propeptide of type III procollagen in patient blood or of collagen hydroxyproline in the urine of AAA patients. It is thought by some that whereas proteolytic degradation of elastin appears to be most specifically related to aneurysmal dilatation, collagen degradation is ultimately required for aneurysm rupture. (Dobrin, P. B. and Mrkvicka, R. *Cardiovascular Surgery*, 2:484-488, 1994).

In addition to collagen and elastin levels, the amount of glycosaminoglycans is slightly decreased, the percentage of chondroitin sulfate is increased, and that of heparan sulfate is significantly decreased in the abdominal aortas of AAA patients. Furthermore, a marked decrease in biglycan mRNA levels is unique to AAA, as compared to atherosclerosis and re-stenosis (Tamarinana et al., *J. Surg. Research* 74:76-80, 1998). Tumor necrosis factor alpha, interleukin-1 beta, interleukin-6 and interleukin-8 have also been shown to be elevated in AAA tissue as compared to controls (Hirose, H., et al., 1997). Further discussion of the role of inflammatory cytokines in AAA will be provided in the next section.

Neovascularization of the aortic wall is also a prominent component of AAA. A significant increase in the density of microvessels in the medial layer of AAA has recently been documented (Holmans, DR et al, *Gay Vasc. Surg.* 21:761-772, 1995). Studies have demonstrated that AAAs are associated with a marked angiogenic response, which is related to the degree of inflammation within the aortic wall. (Thompson MM, et al., "Angiogenesis in

abdominal aortic aneurysm Eur J Vasc Endovasc Surg, 11(4):46 996 May).

AAA tissue has a significantly elevated concentration of nitrite ion, at concentrations that are known to be destructive of elastic fibers in vitro. Endothelial cells of the neovascular nets associated with AAA may produce nitric oxide that has matrix destructive effects. Although not yet established, it is logical to propose that the source of nitrite in AAA tissue could be endogenous (e.g. endothelial cells) or exogenous (e.g. tobacco smoke), or both. The deleterious effect of nitrites on elastin has been observed in a variety of clinical conditions, including premature skin aging and pulmonary emphysema, as well as AAA, all conditions with known associations with cigarette smoking. (Paik DC, et al., "The nitrite/elastin reaction: implications for in vivo degenerative effects," Connect Tissue Res, 36(3):241-51 1997). It is interesting that emphysema/COPD, which involves a deficiency of alpha 1-antitrypsin, appears associated with exacerbation or initiation of AAA. The MZ-alpha 1-antitrypsin phenotype has been found with increased frequencies in individuals with AAA in one study, although this has not been confirmed in a larger series (Cohen, JR et al., J Surg Research 49:319-321, 1990).

4.2b(v) Immune-Mediated Processes in AAA

The complex interaction of a variety of biological processes which act over many years to ultimately weaken the aortic wall, also include chronic inflammation, autoimmune-associated processes, neovascularization, and a decrease in the number of vascular smooth muscle cells, which may explain at least in part the alterations in the balance between matrix-degrading proteinases and their inhibitors, particularly among members of the matrix metalloproteinase (MMP) and plasminogen activator families.

A conspicuous example of the interaction of these various biological processes is found in those patients undergoing surgery for an "inflammatory abdominal aortic aneurysm" (IAAA), a AAA characterized by a massive inflammatory cell infiltrate that extends from the aortic wall into the surrounding tissues. (Grange, J. J. et al. *Cardiovasc. Surg.*, 5:256-265, 1997). This manifestation of AAA is found in 5-10% of AAA patients undergoing surgery. In this condition, the inflammatory processes extend outward from the aortic adventitia to involve surrounding structures, particularly in the retroperitoneum. It has been postulated that this condition arises from an allergic-type process in the adventitia that has the ultimate effect of stimulating localized inflammation and fibrosis. (Di Marzo, et al., "Inflammatory aneurysm of the abdominal aorta. A prospective clinical study," J Cardiovasc Surg (Torino), 40(3):407-12 1999 Jun). Increased collagen deposition in the periaortic tissues has been observed in IAAA, consistent with the established association in AAA and in other settings between chronic inflammation and

stimulation of fibrosis. (M, et al., "Content and turnover of extracellular matrix protein in human "nonspecific" inflammatory abdominal aortic aneurysms," Eur J Vasc Surg, 7(5):546-53 1993 Sep).

Indeed, AAA is associated with a number of inflammatory diseases, including Takayasu's disease (10-30%) and syphilis (66%). (See Pearce, W. H. and Koch, A. E., Annals N. Y. Acad. Sci., 800:175-185, 1996). AAA may also be associated with an autoimmune process targeting certain components of the aortic wall. Additional studies provide evidence of apoptosis and cellular senescence. Certain inflammatory processes affecting blood vessels, termed arteritis, can result in aneurysm formation. Giant cell arteritis and Takayasu's disease are inflammatory processes affecting blood vessels, both with a propensity for insidious development of aneurysms of the thoracic and abdominal aorta which may be accompanied by dissection. (Joyce JW, "Uncommon arteriopathies," in RB Rutherford, ed., Vascular Surgery, WB Saunders, 1989, pp. 276-286). Both conditions are characterized by a localized periarteritis with inflammatory mononuclear cell infiltrates and giant cells, accompanied by disruption and fragmentation of the elastic fibers of the arterial wall. The arterial inflammation in both disorders begins and is most pronounced in the media.

The presence of arterial wall disruption in the predominantly inflammatory disorder of arteritis and the presence of inflammation in those disorders predominately characterized by arterial wall disruption points to an interrelation between inflammation and structural attack on vessel walls. Further, however, an association has been observed in these conditions with abnormal patterns of vascular and perivascular fibrosis. Taken together, the spectrum of changes observed in arterial wall disruptive disorders appears to reflect an accelerated but ineffectual wound healing response to chronic injury and chronic inflammation which is largely localized to the aortic wall.

4.2b(vi) *Fibrotic processes in AAA and arterial wall disruptive disorders*

Normal wound healing is understood to involve mechanisms of inflammation, connective tissue matrix degradation and deposition and scar tissue formation. Generally, wound healing proceeds through discrete sequential stages, including the initial response to injury (with hemorrhage, vasoconstriction and edema formation), inflammation (with the recruitment of leukocytes into the wound and the expression of growth factors), and fibroplasia (with the synthesis and cross-linking of collagen, the production of ground substance in the matrix and the proliferation of new blood vessels). Wound healing that is prolonged because of repeated trauma

underlying pathological chronic wound
or because of an underlying pathological condition results in a chronic wound, where the inflammatory stage of wound repair persists, resulting in extensive tissue damage and ineffective fibroplasia.

Fibroblasts are the primary mesenchymal cells involved in wound healing.

5 Undifferentiated mesenchymal cells in an injured area may be induced to differentiate into fibroblasts when stimulated by macrophage products. More recent data suggest that a subclass of interstitial fibroblasts can play an early role in immune-related processes by direct recruitment of inflammatory cells, release of soluble mediators, and/or promotion of fibroblast-to-immune cell communication. Additional fibroblasts are attracted to the injured area by chemotactic
10 cytokines. PDGF, for example, has been demonstrated to be chemotactic for both fibroblasts and for smooth muscle cells. (Seppa H, et al., "Platelet derived growth factor is a chemoattractant for fibroblasts," J. Cell Biol 92:584-588, 1984; Grotendorst GR et al., "Platelet derived growth factor is a chemoattractant for vascular smooth muscle cells," J. Cell Physiol 112:261-266, 1982). The mesenchymal cell population in a wound is further augmented by the proliferation of
15 both resident and newly arrived cells. Mesenchymal cell proliferation can be stimulated by PGDF, TNF, IL-1, lymphokines, insulin and IGF. Fibroblasts are responsible for the production of collagen in the wound. After the collagen molecule is synthesized within the fibroblast, it is secreted into the extracellular space in the form of procollagen. Procollagen can be identified by persistent nonhelical extensions of the alpha chains of the collagen molecule. Cleavage of this
20 linear extension or registration peptide by enzymes in the extracellular space yields tropocollagen, which can aggregate into collagen fibrils. Intermolecular cross-links form between separate collagen molecules that are replaced by covalent bonds as the fibrils mature. While unaggregated tropocollagen molecules are soluble in saline, strong acid and high temperatures are needed to solubilize maturely cross-linked collagen. Extracellular connective
25 tissue matrix contains components other than collagen, including proteoglycans, attachment proteins such as fibronectin, microfilaments and elastin. Elastin typically is not synthesized as part of an inflammatory, wound healing or injury response, although it may be synthesized in these conditions in some cases.

Response to vascular injury is understood to be a possible explanation for the
30 development of atherosclerosis, a disorder commonly associated with certain arterial wall disruptive disorders, in particular AAA. The atherosclerosis process involves lipid induced biological changes in the arterial walls resulting in a disruption of homeostatic mechanisms that keeps the fluid phase of the blood compartment separate from the vessel wall. Other injuries to the endothelium have also been implicated in atherosclerosis. Injuries as diverse as physical

biological

immunological

injury, ischemia, toxins, ^{biological} injury, mechanical stress and ^{immunological} attack have been associated with atherosclerosis. At least four cell types are involved in the response of the vessel wall to injury: endothelial cells, monocytes, platelets and smooth muscle cells. Each can release growth factors, chemokines, fibrogenic peptides, chemoattractants and synthetic products, intended to reconstitute the injured vascular wall.

The histological progression of atherosclerosis begins with intimal thickening, which may reflect the vessel's adaptation to intraluminal hemodynamic alterations. Intimal thickening and more progressive atherosclerotic lesions are typically identified at vessel bifurcations, where turbulence and shear stress on the endothelium is greatest. The lesion of intimal thickening may progress to form a fatty streak, where fat is seen microscopically in the intimal layer, borne by fat-laden macrophages called foam cells. Fatty streaks may resolve, but more commonly progress to form fibrous plaques. Fibrous plaques are found in the immediate subendothelial region of the vessel wall, consisting of compact and stratified layers of organized smooth muscle cells covered with a fibrous cap. The most advanced atherosclerotic lesions, and those associated with aneurysmal dilatation of the vessel wall, consist of dense fibrous tissue with prominent calcium deposition.

Since the normal response to tissue injury is inflammation, it is understandable that the atherosclerotic lesion shows a complex chronic inflammatory response, including infiltration of mononuclear leukocytes, cell proliferation and migration, reorganization of extracellular matrix, and neovascularization. In fact, the atheromatous plaque consists of a mixture of inflammatory and immune cells, fibrous tissue, and fatty material such as low density lipids (LDL) and modifications thereof, and alpha-lipoprotein. The causes and mechanisms of the atheromatous plaque build-up are not completely understood, though many theories exist. One theory on the pathogenesis of atherosclerosis involves the following stages: (1) endothelial cell dysfunction and/or injury, (2) monocyte recruitment and macrophage formation, (3) lipid deposition and modification, (4) vascular smooth muscle cell proliferation, and (5) synthesis of extracellular matrix.

In its initial phase, the inflammatory response to endothelial injury is characterized by the adherence of leukocytes to the vessel wall. Leukocyte adhesion to the surface of damaged endothelium is mediated by several complex glycoproteins on the endothelial and neutrophil surfaces. Two of these binding molecules have been well-characterized: the endothelial leukocyte adhesion molecule-1 (ELAM-1) and the intercellular adhesion molecule-1 (ICAM-1). During inflammatory states, the attachment of neutrophils to the involved cell surfaces is greatly increased, primarily due to the upregulation and enhanced expression of these binding molecules.

Substances thought to be primary mediators of the inflammatory response to tissue injury, including interleukin-1 (IL-1), tumor necrosis factor alpha (TNF), lymphotoxin and bacterial endotoxins, all increase the production of these binding substances.

After binding to the damaged vessel wall, leukocytes migrate into it. Once in place within the vessel wall, the leukocytes, in particular activated macrophages, then release additional inflammatory mediators, including IL-1, TNF, prostaglandin E₂, (PGE₂), bFGF, and transforming growth factors α and β (TGF α , TGF β). All of these inflammatory mediators recruit more inflammatory cells to the damaged area, and regulate the further proliferation and migration of smooth muscle. A well-known growth factor elaborated by the monocyte-macrophage is monocyte- and macrophage-derived growth factor (MDGF), a stimulant of smooth muscle cell and fibroblast proliferation. MDGF is understood to be similar to platelet-derived growth factor (PDGF); in fact, the two substances may be identical. By stimulating smooth muscle cell proliferation, inflammation can contribute to the development and the progression of myointimal hyperplasia.

Leukocytes, attracted to the vessel wall by the abovementioned chemical mediators of inflammation, produce substances that have direct effects on the vessel wall that may exacerbate the local injury and prolong the healing response. First, leukocytes activated by the processes of inflammation secrete lysosomal enzymes that can digest collagen and other structural proteins. Releasing these enzymes within the vessel wall can affect the integrity of its extracellular matrix, permitting SMCs and other migratory cells to pass through the wall more readily. Hence, the release of these lysosomal proteases can enhance the processes leading to myointimal hyperplasia. Second, activated leukocytes produce free radicals by the action of the NADPH system on their cell membranes. These free radicals can damage cellular elements directly, leading to an extension of a local injury or a prolongation of the cycle of injury-inflammation-healing.

According to this theory, the initiation of atherosclerosis is potentially due to a form of injury, possibly from mechanical stress or from chemical stress. How the body responds to this injury then defines whether, and how rapidly, the injury deteriorates into an atherosclerotic lesion. It is known that following endothelial injury, a series of repair mechanisms are initiated. Within minutes of the injury, a layer of platelets and fibrin is deposited over the damaged endothelium. Within hours to days, inflammatory cells begin to infiltrate the injured area. Within 24 hours after an injury, vascular smooth muscle cells (SMCs) located in the vessel media commence DNA synthesis. A few days later, these activated, synthetic SMCs migrate through the internal elastic lamina towards the luminal surface. A neointima is formed by these

cells by their continued ^{replication} and their production of ^{extracellular} matrix. An increase in the intimal thickness occurs with ongoing cellular proliferation matrix deposition. When these processes of vascular healing progress excessively, pathological conditions result. An overgrowth of smooth muscle cells and neointima, for example, is associated with the development of restenosis after angioplasty.

While the above-described cycle of injury repair in the wall of blood vessels has been described in detail with respect to endothelial injury and the development of atherosclerosis, it is understood that other injuries to the vessel wall are likely to trigger comparable processes of injury repair. For example, the source of vessel wall injury may arise from immunologically activated cells within the vessel wall, or from inflammatory cytokines, or from abnormal proteins or from genetic mutations or abnormalities. Other tissues manifest analogous interactions between tissue injury and repair, with the association of inflammation and fibrotic processes. Conditions in the lung, for example idiopathic pulmonary fibrosis, may manifest the interrelation of these processes, with tissue fibrosis as the pathological outcome. Systemic sclerosis, as another example, is a multisystemic disorder characterized by diffuse tissue fibrosis, wherein immunological mechanisms, vascular damage and fibroblast activation are key events. Renal interstitial fibrosis likewise manifests the combination of immune and non-immune mediated components of injury repair. Other examples of the interaction of inflammation and fibrosis in wound healing will be readily evident to practitioners of ordinary skill in the medical arts. Potential therapeutic targets for treatment of fibrotic conditions include those agents that affect various factors in the injury repair process, for example, those agents that affect $\alpha 1 \beta 1$ integrins, where $\alpha 1 \beta 1$ is understood to mediate signals that induce downregulation of collagen gene expression and $\alpha 2 \beta 1$ is understood to mediate MMP-1 expression, those agents that affect fibroblast proliferation, those agents that affect macrophage activation and recruitment, those agents that affect smooth muscle cell differentiation and proliferation, those agents that affect TGF-beta and other cytokinases and chemokinases, and those agents that affect gene expression, transgenes, etc. Representative therapeutic targets include CTGF, interferons, relaxin, TGF β 3, HGF, prolyl hydroxylase, C-proteinase, lysyl oxidase, and antisense oligonucleotides, although other therapeutic targets will be identified by practitioners in the relevant arts using no more than routine experimentation.

Table 1 presents a list of those molecules whose expression in "choroidal fibrosis" has been evaluated. These molecules represent additional targets for therapeutic manipulations to influence the course of injury repair and fibrosis. Recognizing the association between fibrotic processes and arterial wall disruptive disorders may permit the development of therapeutic

agents directed to those processes that will have a beneficial effect on the development or progression of arterial wall disruptive disorders such as AAA.

TABLE 1

Molecule	Expression in Choroidal Fibrosis vs Controls
BIG H3	Decreased
b1-integrin	Increased
Collagen 3 a1	Unchanged
Collagen 1a1	Unchanged
Collagen 1a2	Unchanged
Collagen 6 a1	Unchanged
Collagen 6 a2	Increased
Collagen 6 a3	Increased
Elastin	Increased
Fibulin-1	Unchanged
Fibulin-2	Unchanged
Fibulin-3	Unchanged
Fibulin-4	Unchanged
Fibulin-5	Unchanged
FBN-2	Unchanged
HLA-DR b	Unchanged
HME	Increased
IgK	Unchanged
Laminin Receptor	Unchanged
Lam C2	Unchanged

Based on the observed associations between inflammation, injury, healing, and related biological phenomena, therefore, one major thrust of AAA research is directed to the inflammatory process and its regulation of arterial wall matrix remodeling. (Grange, J.J., et al. Cardio. Vasc. Surg. 5:256-265, 1997). It is proposed that the presence of inflammatory cells within the media of aneurysmal aortas may play a critical role in the destruction of elastin and collagen through production of matrix-degrading proteinases. (Newman KM, et al., "Matrix

abdominal purification
metalloproteinases in abdominal aortic aneurysm: characterization, purification, and their possible sources," Connect Tissue Res, 30(4):265-76 1994). The presence of inflammatory cells within the media of aneurysmal aortas may play a critical role in the destruction of elastin and collagen through production of matrix-degrading proteinases. The predominant immune cells associated with inflammatory AAA are activated T-cells, and macrophages, dendritic cells and B cells have also been identified. (Lebermann, J. et al., *J. Vasc. Surg.* 15:569-572, 1992). Immune cells have also been associated with expanding AAAs. (Freestone T, et al., "Inflammation and matrix metalloproteinases in the enlarging abdominal a aneurysm," *Arterioscler Thromb Vasc Biol*, 15(8):1145-51 1995 Aug). Vascular dendritic cells (CD1a and S100 positive) have been shown to be present in both the media and the adventitia of the aneurymic aorta, in contact with both CD3, CD4, and CD8 positive T cells or CD20 positive B cells. (Bobryshev, Y.V. et al., *Cardiovascular Surgery*, 6(3):240-249, 1998). Since the T-cell inflammatory reaction resolves after aneurysm replacement, there may be a substance in the aneurysm wall that elicits the inflammatory response. Whether the immune response antedates the aneurysm, or results therefrom, awaits further studies.

Other investigators (Coch, AE et al., *Am. J. Pathol.*, 137:1199-1213, 1990) have provided data to suggest that not only "inflammatory AAA", but also non-inflammatory AAA, is an immune-mediated event. A number of observations support the contention that AAA may be caused by autoimmune response to components of the aortic wall. It has been proposed that ceroid, an "age-pigment" ("aortic content") that leaks into the surrounding tissues in AAA may be the immunogen responsible for this condition (Coch, AE, et al., *AM. J. Pathol.*, 137:1199-1213, 1990; Beckman, EN, *AM. J. Clin. Pathol.*, 85:21-24, 1986; Ball, RY, et al., *Arc. Pathol. Lab. Med.*, 111:1134-1140, 1987; Brophy, CM et al., *Annals Vasc. Surg.*, 5:229-233, 1991; Ball, RY, et al., *Arc. Pathol. Lab. Med.*, 111:1134-1140, 1987). Ceroid, generally considered to be related to the lipofuscin group of pigments, is believed to be derived from previous oxidation of unsaturated lipid or lipid-protein complexes. It is an autofluorescent material that is insoluble in organic solvents and binds lipids-soluble dyes such as oil-red O. In the event of AAA-associated necrosis, ceroid may be spilled from dead cells and subsequently phagocytosed by macrophages. A similar situation occurs in atherosclerosis, where ceroid is abundant in the atheromatous debris of atherosclerotic plaques in drusen and other structures. (Yardley et al., *Arch. Pathol. Lab. Med.* 111:1134-1140, 1987) Furthermore, histologic examination of AAA specimens reveals the presence of Russell bodies, which are hallmarks of autoimmune disease.

In the spectrum of autoimmune disorders, certain HLA alleles play a key role in the presentation of cell-proteins as autoantigens in different specific conditions. A recent study

provides data that Class ~~to compatibility~~ antigens are expressed by vascular smooth muscle cells in human AAA and that these altered smooth muscle cells may be a target for lymphocytes infiltrating the aorta (Kosierkiewicz, TA et al., Surg. Forum 46:365-367, 1995). More recent studies indicate that HLA-DR2(15) has an important role as a genetic risk factor for AAA in the Japanese population (Hirose, H., et al., J. Vasc. Surg. 27:500-503, 1998) and that a genetic risk of determinate can be mapped to the HLA-DRB1 locus of patients with inflammatory AAA (Rasmussen, T.E. et al, J.Vasc. Surg. 25:356-364, 1997).

In some immune-mediated disorders, such as rheumatoid arthritis and glomerulonephritis, immunoglobulin deposition and complement activation are associated with tissue destruction. The complement system is understood to be an important mediator of inflammation and immunity with roles in chemotaxis, macrophage activation, and cell death. The complement cascade is activated in the classical pathway by immunoglobulin M and G, or alternatively, by activating surfaces with tissues. Significant to AAA, Capella et al. (J. Surg. Research 65:31-33, 1996) have demonstrated the presence of elevated levels of C3 and IgG in the aortic wall of AAA donors, lending further support to the notion of an immune-mediated pathophysiology for AAA. The presence of large amounts of IgG in the degenerating media of AAAs has further lead to speculation that a specific immune response might contribute to the etiology of AAA. B-cells have also been identified. (Pasquinelli G, et al., "An immunohistochemical study of inflammatory abdominal aortic aneurysm," J Submicrosc Cytol Pathol, 25(1):103-12 1993 Jan). It is pointed out, however, that in one recent study investigating the repertoire of immunoglobulin heavy chain genes in AAA suggests that, in the vast majority of atherosclerotic AAA, the B-cell rich adventitial infiltrates are not an autoimmune response to a limited repertoire of tissue antigens (Walton, L.J. et al., Atherosclerosis 135:65-71, 1997).

A number of investigators have recently demonstrated that IgG isolated from AAAs react against major protein bands migrating at 40kDa and 80kDa on Western blots of separated AAA aorta extracts (Tilson, MD, Biochem. Biophys. Research Communication, 213:40-43, 1995; Xia, S et al., Biochem. Biophys. Research Communication, 219:36-39, 1996; Gregory AK et al., Arc Surg, 131:85-88, 1996). Further studies of the 40kDa auto-antigen indicate that it has a high degree of amino acid sequence homology to microfibril-associate glycoprotein (MAGP). Because microfibrils serve as architectural scaffolds for tropoelastin deposition during elastogenesis, one might speculate that enzymatic degradation of elastin in AAA exposes previously masked epitopes associated with microfibrillar proteins. This, in turn, might lead to recognition of these epitopes and the initiation of an autoimmune response. Tilson and colleagues (J. Vasc. Surg. 26:313-318, 1997) have purified a protein, designated AAP-40, from

homologous

this protein

the human aorta that is homologous to bovine aortic MAGP-36; this protein in immunoreactive with IgG purified from the serum and aortic wall of patients with AAA. AAAP-40 (as well as MAGP-36) has fibrinogen-like and vitronectin-like motifs and shares similarities with immunoglobulins of the kappa family. Tilson and co-workers have also suggested that some bacterial and viral pathogens (e.g. CMV, herpes virus) may be molecular mimics of AAAP-40, capable of initiating an autoimmune response against self-proteins (Ozsvath, K., et al., *Annals NY Acad. Sci.*, 800:288-293, 1996).

A variety of inflammatory cytokines, chemoattractants, peptide growth factors and immune cells have been found in aneurysm tissues, suggesting a possible model for inflammatory mediators or immune cells in the pathogenesis of the disease. Tumor necrosis factor alpha (TNF α), interleukin-1 β (IL-1 β), interleukin-6 (IL-6) and interleukin-8 (IL-8) are elevated in AAA tissue as compared to controls. (Hirose, H. et al., *J. Vasc. Surg.* 26: 313-318, 1997). IL-1B has been associated with AAA. (Keen RR, et al., "Interleukin-1 beta induces differential gene expression in aortic smooth muscle," *J Vasc Surg*, 20(5):774-84; discussion 784-6 1994 Nov). Perhaps a consequence of increased IL-1 or TNF- α levels, significant elevation of ICAM-1 expression has also been demonstrated in AAA, which may enhance the recruitment of inflammatory cells to the aortic wall. (Davis, C. et al., *J. Vasc. Surg.*, 16:474-475A, 1992; Pearce, W. H., *supra* at 179). In addition, soluble ICAM has been detected in supernatants of AAA diseased tissue, probably due to cleavage of membrane bound ICAM-1. Oxidized LDL or elastin fragments may also initiate the inflammatory response.

Specific factors attracting macrophages and lymphocytes into the aorta have not been reported, but chemotactic elastolytic peptides and other matrix bound mediators of inflammation may serve as a potential stimulus for monocyte infiltration. (Senior, R. M. et al., *J. Cell Biol.*, 99:870-874, 1984). In addition, elevated levels of urokinase-type (uPA) and tissue-type (tPA) plasminogen activators have been documented in AAA tissues and localized to macrophages within the inflammatory infiltrate characteristic of AAA. (Reilly, J. M., *Annals NY Acad. Sci.*, 800:151-156, 1996). Associations between inflammatory cytokines and atherosclerosis are well-established. Cytokine-mediated or immunological mechanisms may overlap between atherosclerosis and atherosclerotic occlusive disease and arterial wall disruptive disorders.

4.2b(vii) Pharmacological Interventions in AAA

It is well established in the art that the treatment for AAA is surgical. There are no pharmacological interventions that are presently employed clinically. Recognition of the underlying pathophysiological processes has permitted conjectures to be made about therapies

that may be valuable in, ^{treating} AAAAs, to stabilize them and ^{prevent their} expansion, to prevent their rupture, or, optimally, to effect their regression. Identification of aneurysm-associated genes may permit the manipulation of DNA, mRNA or proteins related to the development or the progression of AAA. (Grange JJ, et al., "Pathogenesis of abdominal aortic aneurysm: an update and look toward the future," Cardiovasc Surg, 5(3):256-65 1997 Jun). Alternatively, clinical trials of anti-inflammatory agents or protease inhibitors may be warranted. Furthermore, identification of agents that induce or exacerbate aneurysms or other arterial wall disruptive disorders may be important to clinicians so that they can make decisions about avoiding the use of those agents in patients at risk for the development or progression of such disorders, even when the agent in question may have an unrelated beneficial therapeutic effect. Further, as agents are identified with effect in treating arterial wall disruptive disorders, these agents may be applicable also for the treatment of AMD.

The notion that aneurysmal disease shares features in common with other autoimmune diseases opens the way for new approaches to the treatment and prevention of AAA. These treatment modalities in turn may have a beneficial effect on associated diseases such as AMD. If tolerance for an aortic autoantigen could be induced, for example, it might be possible to modulate the progression of aortic degeneration in a fashion similar to that which has been employed in patients with rheumatoid arthritis (Trentham, D.E., et al., Science 261:1727-1730, 1993). Monoclonal antibodies directed to the leukocyte CD-18 molecule have been shown experimentally to reduce inflammation associated with AAA and to slow its expansion. (Ricci MA, et al., "Anti-CD 18 monoclonal antibody slows experimental aortic aneurysm expansion," J Vasc Surg, 23(2):301-7 1996 Feb). Further evaluation of the role of immune-related cell surface molecules and adhesion molecules in the expansion of AAA will allow identification of pharmacological interventions to modulate these receptor sites.

The finding that elastolytic MMPs, particularly MMP9 and MMP2, are expressed and produced in increased amounts in human AAA, has led to the possibility that these enzymes might serve as rationale targets for pharmoco-therapy in this disease (Thompson, R.W. and W.C. Parks Annals N.Y. Acad. Sci., 800:157-174, 1996). Indeed, inhibition of MMP activities has been shown to suppress aortic elastin degradation in vivo in an animal model of AAA. (Thompson RW, et al., "MMP inhibition in abdominal aortic aneurysms. Rationale for a prospective randomized clinical trial," Ann NY Acad Sci, 878(-HD-):159-78 1999 June 30). A number of MMP inhibitors with effect on experimentally induced AAAs have been identified. A hydroxamate based MMP antagonist RS 312908 has been found to inhibit elastase, promote the preservation of elastin in the aortic wall and enhance the pro-fibrotic response therein. (Moore G,

et al., "Suppression of ^{experimental} abdominal aortic aneurysms by ^{by systemic} treatment with hydroxamate-based matrix metalloproteinase inhibitor (RS 132908)," J Vasc Surg, 20(3):522-32 1999 Mar). The MMP inhibitor BB-94 (also known as batimastat) limits the expansion of experimental AAAs by the direct inhibition of MMP and by a further control of the local inflammatory response. (Bigatel DA, et al., "The matrix metalloproteinase inhibitor BB-94 limits expansion of experimental abdominal aortic aneurysms," J Vasc Surg, 29(1):130-8; discussion 138-9 1999 Jan).

Calcium channel blockers have been shown to increase proteolytic activity of metalloproteinases secreted by vascular smooth muscle cells. For example, amlodipine has been identified as an agent that enhances elastin degradation and potentiates MMP-9 activity in tissue cultures. (Boyle JR, et al., "Amlodipine potentiates metalloproteinase activity and accelerates elastin degradation in a model of aneurysmal disease," Eur J Vasc Endovasc Surg, 16(5):408-14 1998 Nov). Further elaboration of this mechanism may permit interventions to counteract MMP activity and thus protect the arterial wall tissue from further degeneration. This finding may also lead clinicians to avoid the use of calcium channel blockers for other cardiovascular conditions in patients at increased risk for aneurysm formation. Identification of other substances that initiate or exacerbate the development of arterial wall disruptive disorders, including aneurysm and dissection, can be anticipated. Once such substances are identified, the clinician is likely to avoid their use in the patient suffering from or at risk for arterial wall disruptive disorders. It may be determined that these agents similarly have a deleterious effect on the development or the progression of AMD.

Further understanding of the basic science of AAAs is likely to lead to the development of further therapeutic strategies that involve the manipulation of proteinases associated with mononuclear inflammatory cells as well as the manipulation of related inflammatory processes. (Thompson RW, "Basic science of abdominal aortic aneurysms: emerging therapeutic strategies for an unresolved clinical problem," Curr Opin Cardiol, 11(5):504-18 1996 Sep). Further understanding of the vascular biology of AAAs may also give rise to unexpected findings with therapeutic implications. For example, certain antibiotics exhibiting MMP-inhibiting properties, e.g., doxycycline, have been studied as inhibiting agents for expansion of experimental aneurysms. (Boyle JR, et al., "Doxycycline inhibits elastin degradation and reduces metalloproteinase activity in a model of aneurysmal disease," J Vasc Surg, 27(2):354-61 1998 Feb). In one study, non-antibiotic tetracyclines and the common antibiotic doxycycline have been identified as having a dose-dependent aneurysm suppressing effect that resulted in limiting the disruption of elastin without altering either the inflammatory response or the aortic wall

production of MMPs (Curci JA, et al., "Pharmacologic suppression of experimental abdominal aortic aneurysms: trial of doxycycline and four chemically modified tetracyclines," J Vasc Surg, 28(6):1082-93 1998 Dec).

General inhibition of inflammation appears to have some effect on limiting the expansion of AAAs. There may be related beneficial effects on AMD. For example, the adverse effects of PGE2 on aortic smooth muscle viability and cytokine secretion are understood in the art. Drugs inhibiting prostaglandin synthesis may be useful in treating or preventing aneurysms. (Walton LJ, et al., "Inhibition of prostaglandin E2 synthesis in abdominal aortic aneurysms: implications for smooth muscle cell viability, inflammatory processes, and the expansion of abdominal aortic aneurysms," Circulation, 100(1):48-54 1999 Jul 6). In the rat model, indomethacin has been shown to inhibit aneurysmal growth, possibly by decreasing macrophage expression of MMP-9. (Holmes DR, et al., "Indomethacin prevents elastase-induced abdominal aortic aneurysms in the rat," J Surg Res, 63(1):305-9 1996 Jun). The role of indomethacin in attenuating aneurysm growth is thought to be mediated by the cox2 isoform of cyclooxygenase, which decreases PGE2 and MMP-9. (Miralles M, et al., "Indomethacin inhibits expansion of experimental aortic aneurysms via inhibiting the cox2 isoform of cyclooxygenase," J Vasc Surg, 29(5):884-92; discussion 892-3 1999 May).

Propranolol, a beta-blocker, has also been documented to suppress aneurysm development in a mouse model of AAA, the mechanism of action thought to be due to enhancement of connective tissue cross-linking (Brophy, CM et al., J. Surg. Research 46:330-332, 1989). Propranolol and related beta-blockers are also known to be effective in reducing systemic hypertension, which is understood to promote the expansion of aneurysms. Beta-blockers and other anti-hypertensive agents form a mainstay of treatment for aortic dissections, a manifestation of arterial wall disruptive disorder not typically associated with AAA. (Dzau VJ et al., "Diseases of the aorta," pp. 1394-1398 in AS Fauci et al., eds., Harrison's Principles of Internal Medicine, 14th Ed., McGraw-Hill 1998).

4.3 Diagnostic Assays

In one aspect, the invention provides a method for diagnosing, or determining a predisposition to developing arterial wall disruptive disorder by detecting one or more markers for macular degeneration in the eye, wherein the marker is indicative of arterial wall disruptive disorder or of a predisposition to developing arterial wall disruptive disorder. In a preferred embodiment, the marker for macular degeneration in the eye is drusen formation or the occurrence of a drusen-associated marker such as a drusen-associated molecule (DRAM) or a

drusen-associated ^{molecular} ~~molec~~ pathology. Examples of drusen-associated ^{associated} ~~associ~~ molecular pathologies include: the presence of disciform scars and/or choroidal neovascularization and/or fibrosis (e.g. spiral collagens, elastin fibrils and microfilaments) in the macula, a change in the pigmentation of the macula, the occurrence of cell death in the RPE, the occurrence of certain immune-mediated events in the eye, and the occurrence of dendritic cell proliferation, migration and differentiation in the sub RPE space.

The drusen-associated markers may be detected by one or more ophthalmological procedures, such as fundus fluorescein angiography (FFA), fundus ophthalmoscopy or photography (FP), electroretinogram (ERG), electrooculogram (EOG), visual fields, scanning laser ophthalmoscopy (SLO), visual acuity measurements, dark adaptation measurements or other standard method.

In one method of the invention, the occurrence of a drusen-associated disorder may be detected by conventional ophthalmological methods in which a patient's eye is examined for the presence of drusen. Drusen are subretinal pigment epithelial deposits that are characteristic of but not uniquely associated with age-related macular degeneration (AMD). Age-related macular degeneration is associated with two types of drusen that have different clinical appearances and different prognoses. Hard drusen appear as small, punctate, yellow nodules and can precede the development of atrophic AMD. Areolar atrophy of the retinal pigment epithelium (RPE), choriocapillaris, and outer retina develop as the drusen disappear, but drusen can regress without evidence of atrophy. Soft drusen appear as large (usually larger than 63 microm in diameter), pale yellow or grayish-white, dome-shaped elevations that can resemble localized serous RPE detachments. They tend to precede the development of clinically evident RPE detachments and choroidal neovascularization. Drusen characteristics correlated with progression to exudative maculopathy include drusen number (five or more), drusen size (larger than 63 microm in diameter), and confluence of drusen. Focal hyperpigmentation in the macula and systemic hypertension also are associated with an increased risk of developing choroidal new vessels (CNVs). Large drusen are usually a sign of diffuse thickening of Bruch's membrane with basal linear deposit, a vesicular material that probably arises from the RPE, constitutes a diffusion barrier to water-soluble constituents in the plasma, results in lipidization of Bruch's membrane, and creates a potential cleavage plane between the RPE basement membrane and the inner collagenous layer of Bruch's membrane through which CNVs can grow.

Other drusen-associated molecular pathologies include the occurrence of distinct fundus appearances in the eye such as white to yellow fundus spots (which are distinct from drusen)

disciform

deposits

which accompany a disciform macular degeneration, or yellow deposits which are associated with atrophic macular degeneration. These AMD-associated fundus findings also include geographic atrophy (GA, which is characteristic of the dry form of AMD), and disciform scars and choroidal neovascularization (DS/CNV, which is characteristic of the wet form of AMD). In other instances, the AMD-associated fundus findings do not distinguish between the wet or dry form.

In a preferred embodiment, the marker is molecular marker associated with drusen deposits - i.e. a drusen-associated molecules (DRAM). Drusen may be detected by determining the presence of one or more DRAMs, such as amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, b2 microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin and vitronectin. In another embodiment, the drusen-associated marker is a molecule whose production is altered in a drusen-associated molecular pathological process. For example, one pathological process associated with drusen is cell death and/or dysfunction in the retinal pigment epithelium (RPE). A number of molecular markers have been associated with such dysfunctional RPE cells including: HLA-DR, CD68, vitronectin, apolipoprotein E, clusterin and S-100. HLA-DR expression is particularly unique for non-immunocompetent cells (although it is frequently expressed by cells early in an immune reaction). Still other molecular markers associated with dysfunctional RPE cells of AMD-affected eyes include gene products associated with cell death such as: death protein, heat shock protein 70, proteasome, Cu/Zn superoxide dismutase, cathepsins, and death adaptor protein RAIDD. Furthermore, drusen biogenesis is facilitated by various immune-mediated events such as the production of autoantibodies in the sera of AMD patients. These autoantibodies are directed against drusen, the RPE and other retinal components. Accordingly, the invention provides for diagnostic assays designed to detect the presence and antigen specificity of such autoantibodies by methods known in the art, including standard immunohistochemical and Western blot techniques. Furthermore a number of immune system-associated molecules, including Ig mu, lambda, J, and kappa chains, are up-regulated in the RPE/choroid in conjunction with the formation of drusen. Accordingly, the these immune-associated molecules provide another target for protein-based (e.g. antibody-based detection methods) and nucleic acid-based (e.g. Northern, and RT-PCR methods) diagnostic assays. Still other drusen-associated molecular markers are those found in conjunction with subpopulation of choroidal cells that possess cellular processes which breach Bruch's membrane and terminate as bulbous,

withing *marker molecules*

vesicle-filled "cores" ~~withing~~ the centers of drusen. Specific ~~marker~~ *marker molecules* associated with these dendritic cells include: CD1a, CD4, CD14, CD68, CD83, CD86 and CD45. Other molecular markers appear to be associated with drusen-associated dendritic cell cores include: PECAM, MMP14, ubiquitin, and FGF. In yet another aspect of the invention, the drusen-associated marker may be a cytokine which facilitates the development of drusen via a receptor-ligand interaction between a dendritic cell precursor and an injured tissue. Such cytokines include: IL-1, IL-6, IL-12, TNF-alpha, and GM-CSF. Other molecules involved in drusen development include GM-CSF, heat shock proteins, and DNA fragments. In one embodiment, the sample obtained from the subject is a blood or urine sample, obtained according to standard methods in the art. In another embodiment, a sample is derived from a tissue, which may be obtained by biopsy. Alternatively, the sample may be a DNA or RNA sample, obtained from, for example, blood or other fluid or from a tissue and is purified according to standard molecular biology methods. The markers may be detected by analyzing the presence of protein by standard techniques or by analyzing the RNA of a subject, e.g., by polymerase chain reaction (PCR), thereby determining the RNA expression levels of a DRAM or other drusen-associated marker.

In another embodiment, the invention provides a method for diagnosing, or detecting a predisposition to developing, an arterial wall disruptive disorder in a subject, comprising performing an immunoassay on a sample obtained from the subject using an antibody specific for a gene product indicative of macular degeneration, wherein detection of the presence of bound antibody indicates that the subject has macular degeneration or a predisposition to developing macular degeneration and therefore has an arterial wall disruptive disorder or a predisposition for developing an arterial wall disruptive disorder. The antibody may be obtained by standard methods and may be a monoclonal antibody or a polyclonal antibody.

In another embodiment, a kit for diagnosing arterial wall disruptive disorder is provided, comprising reagents for performing the immunoassay. In another embodiment, the kit for diagnosing arterial wall disruptive disorder comprises specific primers for amplifying a region of a chromosome having a polymorphism indicative of macular degeneration, reagents for performing DNA amplification and reagents for analyzing the amplified nucleic acid. The methods described herein may be performed, for example, by utilizing pre-packaged diagnostic kits comprising at least one probe nucleic acid, primer set; and/or antibody reagent described herein, which may be conveniently used, e.g., in clinical settings to diagnose patients exhibiting symptoms or family history of a disease or illness involving macular degeneration. The kit may detect abnormal levels, form or activity of one or more DRAM proteins, RNAs or a breakdown

more DRAM

embodiment

products of one or more DRAM proteins or RNAs. In an embodiment of the invention, the kit detects autoantibodies specific for DRAM proteins, peptides or nucleic acids. For example, the kit can comprise a labeled compound or agent capable of detecting DRAM proteins or mRNAs in a biological sample; means for determining the amount of DRAM protein in the sample (e.g., a blood, urine or biopsy sample); and means for comparing the amount of DRAM protein in a sample from a macular degeneration-afflicted subject compared to a sample from a normal, healthy subject. The compound or agent can be packaged in a suitable container. The kit can further comprise instructions for using the kit to detect DRAM mRNAs or proteins. Such a kit can comprise, e.g., one or more nucleic acid probes capable of hybridizing specifically to at least a portion of a DRAM gene or allelic variant thereof, or mutated form thereof. Preferably the kit comprises at least one oligonucleotide primer capable of differentiating between a normal DRAM gene and a DRAM gene with one or more nucleotide differences.

Another aspect of the invention pertains to an antibody specifically reactive with a DRAM or other component of drusen. See, e.g., *Antibodies: A Laboratory Manual*, ed. by Harlow and Lane, Cold Spring Harbor Press, 1988. A mammal, such as a mouse, a hamster or rabbit can be immunized with an immunogenic form of the peptide (e.g., an antigenic fragment which is capable of eliciting an antibody response, or a fusion protein as described above). Techniques for conferring immunogenicity on a protein or peptide include conjugation to carriers or other techniques well known in the art. The progress of immunization can be monitored by detection of antibody titers in plasma or serum. Standard ELISA or other immunoassays can be used with the immunogen as antigen to assess the levels of antibodies.

The invention provides methods for obtaining antibodies directed at a DRAM, using similar methodologies. Anti-DRAM antibodies are useful for visualization of DRAMs in drusen, inhibiting DRAM function or accumulation or for encouraging DRAM resolution. The procedure for obtaining such antibodies is well known in the art and is provided briefly below.

Following immunization of an animal with an antigenic preparation of a DRAM polypeptide or another drusen-associated molecular marker, specific antisera can be obtained and, if desired, polyclonal antibodies isolated from the serum. To produce monoclonal antibodies, antibody-producing cells (lymphocytes) can be harvested from an immunized animal and fused by standard somatic cell fusion procedures with immortalizing cells such as myeloma cells to yield hybridoma cells. Such techniques are well known in the art, and include, for example, the hybridoma technique, Kohler and Milstein (1975), *Nature* 256: 495-497, the human B cell hybridoma technique, Kozbar et al. (1983), *Immunol. Today* 4: 72, and the EBV-

produce

cole et

hybridoma technique to ~~use~~ human monoclonal antibodies. ~~et al.~~ (1985), *Monoclonal Antibodies and Cancer Therapy*, Alan R. Liss, Inc. pp. 77-96. Hybridoma cells can be screened immunochemically for production of antibodies specifically reactive with a dendritic cell, DRAM polypeptide of the present invention and monoclonal antibodies isolated from a culture comprising such hybridoma cells.

The term antibody as used herein is intended to include fragments thereof which are also specifically reactive with one of the subject dendritic cell, DRAM polypeptides. Antibodies can be fragmented using conventional techniques and the fragments screened for utility in the same manner as described above for whole antibodies. For example, F(ab)₂ fragments can be generated by treating antibody with pepsin. The resulting F(ab)₂ fragment can be treated to reduce disulfide bridges to produce Fab fragments. The antibody of the present invention is further intended to include biospecific, single-chain, and chimeric and humanized molecules having affinity for a dendritic cell, DRAM protein conferred by at least one CDR region of the antibody. In preferred embodiments, the antibody further comprises a label attached thereto and able to be detected, (e.g., the label can be a radioisotope, fluorescent compound, enzyme or enzyme co-factor).

Further, anti-DRAM antibodies can be used, e.g., to monitor DRAM protein levels, respectively, in an individual for determining, e.g., whether a subject has a disease or condition associated with an aberrant DRAM protein level, or allowing determination of the efficacy of a given treatment regimen for an individual afflicted with such a disorder, which is linked to arterial wall disruptive disorder. The level of DRAM polypeptides may be measured from cells in bodily fluid, such as in blood samples. Alterations in DRAM composition or DRAM protein levels are indicia of the efficacy of an agent provided for arterial wall disruptive disorder or macular degeneration.

Another application of DRAM antibodies of the present invention is in the immunological screening of cDNA libraries constructed in expression vectors such as λ gt11, λ gt18-23, λ ZAP, and λ ORF8. Messenger libraries of this type, having coding sequences inserted in the correct reading frame and orientation, can produce fusion proteins. For instance, λ gt11 can produce fusion proteins whose amino termini consist of β -galactosidase amino acid sequences and whose carboxy termini consist of a foreign polypeptide. Antigenic epitopes of a DRAM protein, e.g., other orthologs of a particular DRAM protein or other paralogs from the same species, can then be detected with antibodies, as, for example, reacting nitrocellulose filters lifted from infected plates with such antibodies. Positive phage detected by this assay can then be

infected plate *homologs*

isolated from the ~~infected~~ ~~plate~~. Thus, the presence of DRAM ~~homologs~~ can be detected and cloned from other animals, as can alternate isoforms (including splice variants) from humans.

The invention provides methods for identifying autoantibodies to DRAMs. For example, naturally occurring autoantibodies may be caused by an autoimmune disease involving antibodies directed at DRAMs or nucleic acids. The DRAM nucleic acids and proteins disclosed herein provide assays (e.g., immunoassays) for the detection, isolation and characterization of specific DRAM antibodies. For example, the characterization of DRAM autoantibodies encompasses the characterization and isolation of the DRAM autoantibody antigen or epitope.

4.3.1. Cell-free assays

Cell-free assays can be used to identify compounds which are capable of interacting with a drusen-associated marker gene product or binding partner, to thereby modify the activity of the drusen-associated marker gene protein or binding partner. Such a compound can, e.g., modify the structure of an drusen-associated marker gene protein or binding partner and thereby effect its activity. Cell-free assays can also be used to identify compounds which modulate the interaction between a drusen-associated marker gene protein and an drusen-associated marker gene binding partner, such as a target peptide. In a preferred embodiment, cell-free assays for identifying such compounds consist essentially in a reaction mixture containing an drusen-associated marker gene protein and a test compound or a library of test compounds in the presence or absence of a binding partner. A test compound can be, e.g., a derivative of an drusen-associated marker gene binding partner, e.g., a biologically inactive target peptide, or a small molecule.

Accordingly, one exemplary screening assay of the present invention includes the steps of contacting a drusen-associated marker gene protein or functional fragment thereof or a drusen-associated marker gene binding partner with a test compound or library of test compounds and detecting the formation of complexes. For detection purposes, the molecule can be labeled with a specific marker and the test compound or library of test compounds labeled with a different marker. Interaction of a test compound with a drusen-associated marker gene protein or fragment thereof or a drusen-associated marker gene binding partner can then be detected by determining the level of the two labels after an incubation step and a washing step. The presence of two labels after the washing step is indicative of an interaction.

An interaction between molecules can also be identified by using real-time BIA

(Biomolecular Interaction analysis, Pharmacia Biosensor AB) which detects surface plasmon resonance (SPR), an optical phenomenon. Detection depends on changes in the mass concentration of macromolecules at the biospecific interface, and does not require any labeling of interactants. In one embodiment, a library of test compounds can be immobilized on a sensor surface, e.g., which forms one wall of a micro-flow cell. A solution containing the drusen-associated marker gene protein, functional fragment thereof, drusen-associated marker protein analog or drusen-associated marker gene binding partner is then flown continuously over the sensor surface. A change in the resonance angle as shown on a signal recording, indicates that an interaction has occurred. This technique is further described, e.g., in BIA technology Handbook by Pharmacia.

Another exemplary screening assay of the present invention includes the steps of (a) forming a reaction mixture including: (i) a drusen-associated marker gene polypeptide, (ii) a drusen-associated marker gene binding partner, and (iii) a test compound; and (b) detecting interaction of the drusen-associated marker gene and the drusen-associated marker gene binding protein. The drusen-associated marker gene polypeptide and drusen-associated marker gene binding partner can be produced recombinantly, purified from a source, e.g., plasma, or chemically synthesized, as described herein. A statistically significant change (potentiation or inhibition) in the interaction of the drusen-associated marker gene and drusen-associated marker gene binding protein in the presence of the test compound, relative to the interaction in the absence of the test compound, indicates a potential agonist (mimetic or potentiator) or antagonist (inhibitor) of drusen-associated marker gene bioactivity for the test compound. The compounds of this assay can be contacted simultaneously. Alternatively, a drusen-associated marker gene protein can first be contacted with a test compound for an appropriate amount of time, following which the drusen-associated marker gene protein binding partner is added to the reaction mixture. The efficacy of the compound can be assessed by generating dose response curves from data obtained using various concentrations of the test compound. Moreover, a control assay can also be performed to provide a baseline for comparison. In the control assay, isolated and purified MFGF polypeptide or binding partner is added to a composition containing the drusen-associated marker gene protein binding partner or drusen-associated marker gene polypeptide, and the formation of a complex is quantitated in the absence of the test compound.

Complex formation between a drusen-associated marker gene protein and a drusen-associated marker gene binding partner may be detected by a variety of techniques. Modulation of the formation of complexes can be quantitated using, for example, detectably labeled proteins

fluorescently

labeled drusen

such as radiolabeled, fluorescently labeled, or enzymatically labeled drusen-associated marker gene proteins or drusen-associated marker gene binding partners, by immunoassay, or by chromatographic detection.

Typically, it will be desirable to immobilize either drusen-associated marker gene protein or its binding partner to facilitate separation of complexes from uncomplexed forms of one or both of the proteins, as well as to accommodate automation of the assay. Binding of drusen-associated marker gene protein to a drusen-associated marker gene product binding partner, can be accomplished in any vessel suitable for containing the reactants. Examples include microtitre plates, test tubes, and micro-centrifuge tubes. In one embodiment, a fusion protein can be provided which adds a domain that allows the protein to be bound to a matrix. For example, glutathione-S-transferase (GST) fusion proteins can be adsorbed onto glutathione sepharose beads (Sigma Chemical, St. Louis, MO) or glutathione derivatized microtitre plates, which are then combined with the drusen-associated marker gene product binding partner, e.g. an ³⁵S-labeled drusen-associated marker gene product binding partner, and the test compound, and the mixture incubated under conditions conducive to complex formation, e.g. at physiological conditions for salt and pH, though slightly more stringent conditions may be desired. Following incubation, the beads are washed to remove any unbound label, and the matrix immobilized and radiolabel determined directly (e.g. beads placed in scintillant), or in the supernatant after the complexes are subsequently dissociated. Alternatively, the complexes can be dissociated from the matrix, separated by SDS-PAGE, and the level of drusen-associated marker gene product protein or associated binding partner found in the bead fraction quantitated from the gel using standard electrophoretic techniques such as described in the appended examples.

Other techniques for immobilizing proteins on matrices are also available for use in the subject assay. For instance, either drusen-associated marker gene product or its cognate binding partner can be immobilized utilizing conjugation of biotin and streptavidin. For instance, biotinylated drusen-associated marker molecules can be prepared from biotin-NHS (N-hydroxy-succinimide) using techniques well known in the art (e.g., biotinylation kit, Pierce Chemicals, Rockford, IL), and immobilized in the wells of streptavidin-coated 96 well plates (Pierce Chemical). Alternatively, antibodies reactive with drusen-associated marker gene product can be derivatized to the wells of the plate, and MFGF trapped in the wells by antibody conjugation. As above, preparations of a drusen-associated marker gene binding protein and a test compound are incubated in the presenting wells of the plate, and the amount of complex trapped in the well can be quantitated. Exemplary methods for detecting such complexes, in addition to those

described above for the immobilized complexes, include ~~imm~~ ~~et~~ection of complexes using antibodies reactive with the drusen-associated marker gene product binding partner, or which are reactive with drusen-associated marker gene protein and compete with the binding partner; as well as enzyme-linked assays which rely on detecting an enzymatic activity associated with the binding partner, either intrinsic or extrinsic activity. In the instance of the latter, the enzyme can be chemically conjugated or provided as a fusion protein with the drusen-associated marker gene binding partner. To illustrate, the drusen-associated marker gene product binding partner can be chemically cross-linked or genetically fused with horseradish peroxidase, and the amount of polypeptide trapped in the complex can be assessed with a chromogenic substrate of the enzyme, e.g. 3,3'-diamino-benzadine tetrahydrochloride or 4-chloro-1-naphthol. Likewise, a fusion protein comprising the polypeptide and glutathione-S-transferase can be provided, and complex formation quantitated by detecting the GST activity using 1-chloro-2,4-dinitrobenzene (Habig et al (1974) J Biol Chem 249:7130).

For processes which rely on immunodetection for quantitating one of the proteins trapped in the complex, antibodies against the protein, such as anti-drusen-associated marker gene product antibodies, can be used. Alternatively, the protein to be detected in the complex can be "epitope tagged" in the form of a fusion protein which includes, in addition to the drusen-associated marker gene sequence, a second polypeptide for which antibodies are readily available (e.g. from commercial sources). For instance, the GST fusion proteins described above can also be used for quantification of binding using antibodies against the GST moiety. Other useful epitope tags include myc-epitopes (e.g., see Ellison et al. (1991) J Biol Chem 266:21150-21157) which includes a 10-residue sequence from c-myc, as well as the pFLAG system (International Biotechnologies, Inc.) or the pEZZ-protein A system (Pharmacia, NJ).

Cell-free assays can also be used to identify compounds which interact with an drusen-associated marker gene protein and modulate an activity of an drusen-associated marker gene protein. Accordingly, in one embodiment, a drusen-associated marker gene product protein is contacted with a test compound and the catalytic activity of drusen-associated marker gene is monitored. In one embodiment, the ability of drusen-associated marker gene product to bind a target molecule is determined. The binding affinity of drusen-associated marker gene to a target molecule can be determined according to methods known in the art. Determination of the enzymatic activity of drusen-associated marker gene can be performed with the aid of the substrate furanacryloyl-L-phenylalanyl-glycyl-glycine (FAPGG) under conditions described in Holmquist et al. (1979) Anal. Biochem. 95:540 and in U.S. Patent No. 5,259,045.

4.3.2. ~~Cell based assays~~

In addition to cell-free assays, such as described above, drusen-associated marker gene proteins as provided by the present invention, facilitate the generation of cell-based assays, e.g., for identifying small molecule agonists or antagonists. In one embodiment, a cell
5 expressing a drusen-associated marker gene product receptor protein on the outer surface of its cellular membrane is incubated in the presence of a test compound alone or in the presence of a test compound and a drusen-associated marker gene protein and the interaction between the test compound and the drusen-associated marker gene product receptor protein or between the
10 drusen-associated marker gene protein and the drusen-associated marker gene product receptor is detected, e.g., by using a microphysiometer (McConnell et al. (1992) Science 257:1906). An interaction between the drusen-associated marker gene product receptor protein and either the test compound or the MFGF protein is detected by the microphysiometer as a change in the acidification of the medium. This assay system thus provides a means of identifying molecular
15 antagonists which, for example, function by interfering with drusen-associated marker gene product - receptor interactions, as well as molecular agonist which, for example, function by activating a drusen-associated marker gene receptor.

Cell based assays can also be used to identify compounds which modulate expression of an drusen-associated marker gene, modulate translation of a drusen-associated marker gene mRNA, or which modulate the stability of a drusen-associated marker gene mRNA or protein.
20 Accordingly, in one embodiment, a cell which is capable of producing drusen-associated marker gene, e.g., a retinal epithelial cell, is incubated with a test compound and the amount of drusen-associated marker gene produced in the cell medium is measured and compared to that produced from a cell which has not been contacted with the test compound. The specificity of the compound vis a vis drusen-associated marker gene can be confirmed by various control analysis,
25 e.g., measuring the expression of one or more control genes. Compounds which can be tested include small molecules, proteins, and nucleic acids. In particular, this assay can be used to determine the efficacy of drusen-associated marker gene antisense molecules or ribozymes.

In another embodiment, the effect of a test compound on transcription of an drusen-associated marker gene is determined by transfection experiments using a reporter gene
30 operatively linked to at least a portion of the promoter of an drusen-associated marker gene. A promoter region of a gene can be isolated, e.g., from a genomic library according to methods known in the art. The reporter gene can be any gene encoding a protein which is readily quantifiable, e.g, the luciferase or CAT gene. Such reporter gene are well known in the art.

further *the above*

This invention ~~is~~ pertains to novel agents identified by ~~the~~ above-described screening assays and uses thereof for treatments as described herein.

4.4 Arterial Wall Disruptive Disorders and AMD

A number of striking similarities exist between the structure, composition, and pathology of the ocular RPE-Bruch's membrane-choroid complex and that of the arterial wall. Additional similarities are observed between the various known risk factors for diseases, namely macular degeneration and arterial wall disruptive disorders, caused by pathological changes in these tissues. These shared risk factors include heritability, exacerbation by hypertension, smoking, age, and potential associations with chronic obstructive pulmonary disease, α 1-antitrypsin deficiency, and atherosclerosis.

The RPE-Bruch's membrane-choroid complex is comprised of a confluent epithelial cell monolayer, a laminar collagen-elastin-collagen matrix referred to as Bruch's membrane, and a choroidal stroma comprised of loosely arranged fibroblasts, smooth muscle cells, pericytes, capillaries, bundles of collagen fibers (near the scleral junction), and other extracellular matrix constituents. The overlying sclera is comprised largely of densely packed collagen and some elastin. Bruch's membrane is a trilaminar extracellular matrix complex that lies between the retinal RPE and the primary capillary bed of the choroid, the choriocapillaris. Bruch's membrane is comprised of two collagen layers, referred to as the inner and outer collagenous layers, that flank a central domain comprised largely of elastin. The strategic location of Bruch's membrane between the retina and its primary source of nutrition, the choroidal vasculature, is essential for normal retinal function (Marshall et al, 1998; Guymer and Bird, 1998). Immunohistochemical studies have documented the presence of collagen types I, III, IV, V, and VI within Bruch's membrane proper [Das, 1990 #670; Marshall, 1992 #671]. Type VI is associated specifically with the elastic lamina, types IV and V with the basal laminae of the choriocapillaris and RPE, and types I and III with the inner and outer collagenous layers. The presence of collagen types I, III, IV and V in these tissues has been confirmed biochemically. Histochemical studies have suggested the presence of glycosphingolipids in Bruch's membrane [Farkas, 1971 #38].

In addition to these structural and compositional similarities, pathogenic mechanisms similar to those described for arterial wall disruptive disorders (AAA, TAA, TAAA, acute dissecting aneurysms, aortic stenosis, atherosclerosis) are observed within the RPE-Bruch's membrane-choroid complex. Distinct pathologic features associated with arterial disease include the deposition and rupture of protein-lipid plaques; degradation of elastin and collagen; up-

and/or down-regulation of various extracellular matrix proteins and associated constituents; infiltration of inflammatory cells, including dendritic cells; generation of autoantibodies directed against extracellular components of the vessel wall; "chronic inflammation"; neovascularization; and proliferation of fibroblasts and smooth muscle cells/pericytes. In many respects, many of the age-related changes in Bruch's membrane parallel those observed in the vascular wall during atherosclerosis [Bilato, 1996 #680].

Pathological changes known to occur within Bruch's membrane in aging and age-related diseases, including AMD, that are similar to those in arterial wall disruptive disorders include: the deposition of abnormal extracellular deposits referred to as drusen, basal laminar deposits, and basal linear deposits (Hageman, 1997; Marshall et al., 1998; Guymer and Bird, 1998), progressive thickening (Feeney-Burns and Ellersieck, 1985; Bird, 1992; Newsome et al, 1987a,b; Ramrattan et al, 1994), accumulation of lipids and other extracellular material (Pauleikhoff et al, 1990, 1992; Sheraidah et al, 1993; Holz et al, 1994a,b), changes in the degree of calcification and fragmentation (Spraul and Grossniklaus, 1997), modification and degeneration of collagen and elastin (Feher and Valu, 1967), increase in the advanced glycation end (AGE) products pentosidine and carboxymethyllysine (Ishibashi et al, 1998; Hanada et al, 1999), and an overall increase in the amount of noncollagenous proteins in the macula, but not the periphery (Hewitt et al, 1989; Karatowski et al, 1995); and a significant decline in the solubility of Bruch's membrane collagen with age, from 100% in the first decade to 40-50% in the ninth decade (Wojciech). Functionally, these processes may cause the exponential reduction in the hydraulic conductivity of Bruch's membrane that has been documented to occur with age (Moore et al, 1995; Starita et al, 1996; Hodgetts et al, 1998a,b) which, intuitively, must impair normal function of the RPE-Bruch's membrane interface. The fact that debris accumulates first in the inner collagenous layer (Feeney-Burns and Ellersieck, 1985; Newsome et al, 1987) may suggest that the elastic lamina is an important site of resistance to permeability with age. This age-related interruption of bulk flow through Bruch's membrane may result in pigment epithelial detachments (Bird, 1992), having a profound effect on the physiology of the RPE.

Thus, it appears that many of the basic structural and functional properties of Bruch's membrane likely depend on the integrity and nature of its collagen and elastin fibers. Choroidal neovascularization is a common manifestation of the exudative form of AMD, typically resulting in severe vision loss. It is likely that degradation of collagen and elastin in Bruch's membrane represents a crucial step in this process. Indeed, MMP-2 and MMP-9, two metalloproteinases with elastolytic properties, increase in Bruch's membrane with age (Guo et al, 1997). These

which are inflammation metalloproteinases, which are typically secreted at sites of inflammation, cause the destruction of elastin in diseases such as emphysema, atherosclerosis, and arthritis, and may be responsible for similar pathology in Bruch's membrane. Moreover, TIMP-3 has been shown to be synthesized by RPE and choroidal endothelial cells and is found in relatively high concentrations in Bruch's membrane and drusen (Vranka et al, 1997). Thus, this inhibitor of metalloproteinases may play a major role in maintaining ECM homeostasis in Bruch's membrane. It is known that elastin fragmentation products are capable of inducing macrophage migration (Kamisato et al, 1997) and are potent stimulators of angiogenesis/neovascularization. Thus, it is logical to propose that any AMD-associated process that leads to the destruction of the elastic lamina may also induce choroidal neovascularization.

Far less is known pertaining to the changes that occur in the choroidal stroma proper in macular disease. It is known that there is a significant loss of capillary endothelial cells, especially in the macula. In addition, there has been some suggestion that the choroid thins with age and AMD, although this has not been rigorously documented.

Studies conducted in our laboratory provide additional new insight into the similarities between macular degeneration and arterial wall disruptive disorders. These include:

1) A strong statistical correlation between AAA and neovascular AMD ($P < 0.00001$) has been documented in a large repository of human donor eyes.

2) In a small clinical trial, five out of eight patients with AAA were diagnosed with a characteristic AAA fundus phenotype and AMD when examined ophthalmoscopically.

3) A review of patients seen at the University of Iowa over the past five years for both AAA and AMD reveals a similar AAA fundus phenotype.

4) Rigorous histochemical and biochemical analyses of drusen have revealed that drusen and arterial disease plaques are similar in composition.

5) Significantly, a novel association between drusen and dendritic cells has been identified.

6) Ultrastructural and immunohistochemical examination of choroids from 151 human donors between 6 hours and 101 years of age, with and without AMD and various arterial wall disruptive disorders (AAA, TAA, TAAA, acute dissecting aneurysms, aortic stenosis, atherosclerosis), has revealed a novel pathology associated with these conditions. The choroidal stromas of 30 of these individuals are filled with newly synthesized collagen, elastin,

microfilaments proteins

elastin-associated microfilaments, and other distinct structural proteins and fibrils. Based on preliminary immunohistochemical analyses, the collagen associated with this condition appears to be largely type III and VI and typically exhibits a "spiraled", or "frayed" morphology that is often associated with specific hereditary and acquired diseases. This previously undescribed phenomenon, referred to as "choroidal fibrosis", shares many pathological features that are common in arterial wall disruptive disorders.

7) RT-PCR analyses of RPE-choroid complexes derived from a series of control (non-diseased) and affected (AMD/AAA, AMD, AMD/aortic stenosis) donors have revealed distinct patterns of up- and down-regulated gene expression between the two groups. These include "upregulation" of b1 integrin, elastin, collagen VIa2, collagen a3, PI-1 (antitrypsin), PI-2, human metalloelastase (and perhaps fibrillin-2) and "downregulation" of BigH3. No detectable differences in expression levels of collagen IIIa1, collagen Ia2, collagen 6a1, fibulins-1, 2, 3, 4, and 5, HLA-DR, Ig kappa, laminin receptor, or laminin C2 were observed. Because of the limitations of RT-PCR, additional real time quantitative RT-PCR studies are being conducted to assess the precise levels of these genes in the two groups.

8) Autoantibodies directed against two specific RPE-, retina- (approximately 35kDa and 50kDa), and drusen-associated (approximately 42kDa) proteins have been identified in the sera of patients with both AMD and AAA, suggesting additional similarities between the mechanisms of AMD and arterial diseases.

9) Gene array analyses of RPE/choroid tissues derived from human donors with AMD and/or AAA have provided compelling evidence for shared mechanisms of pathogenesis (gene expression profiles) between these disorders.

10) Immunohistochemical analyses have documented that the elastic lamina in the macula of AMD donors is thinner and more fragmented than that in the extramacular regions. These data indicate that degradation of elastin in the macula is more robust than in the periphery. Conversely, since most elastin synthesis occurs during gestation in humans, any postnatal synthesis of elastin that occurs in the macula might be expected to differ significantly in amount and/or content as compared to elastin that is synthesized earlier.

4.5 Predictive Medicine

The invention further features predictive medicines, which are based, at least in

the novel

alterations

part, on the identity of ~~the~~ ^{the novel} AAA/AMD-associated genes and ~~alterations~~ ^{alterations} in the genes and related pathway genes, which affect the expression level and/or function of the encoded protein in a subject. For example, the invention provides a method for diagnosing, or determining a predisposition to, arterial wall disruptive disorder in a subject, comprising isolating a nucleic acid from a subject and genotyping the nucleic acid wherein at least one allele from a macular degeneration-associated haplotype is predictive of an increased risk of arterial wall disruptive disorder. In another embodiment the invention provides a method for diagnosing, or determining a predisposition to, arterial wall disruptive disorder in a subject having family members diagnosed with macular degeneration, comprising isolating a nucleic acid from a subject, amplifying the nucleic acid with primers which amplify a region of a chromosome corresponding to a polymorphic marker for AMD and analyzing the amplification product, wherein the presence of a polymorphism indicative of an allele type linked to macular degeneration is indicative of an allele type linked to arterial wall disruptive disorder or a predisposition for developing arterial wall disruptive disorder. In yet another embodiment, the invention provides a method for diagnosing, or determining a predisposition to, arterial wall disruptive disorder in a subject having family members diagnosed with macular degeneration, comprising isolating a genomic nucleic acid from a subject amplifying short tandem repeat sequences in the genomic DNA to obtain a genotype, comparing the genotype to the genotype of known DNA sequences to detect nucleotide sequence polymorphisms and determining the presence or absence of a polymorphism in the genomic DNA of the subject, wherein the presence of a polymorphism indicative of an allele type linked to macular degeneration is indicative of an allele type linked to arterial wall disruptive disorder or a predisposition for developing arterial wall disruptive disorder. In a preferred embodiment, the genotype substantially corresponds to a region of the short arm of human chromosome 2 bordered by marker D2S2352 and D2S1364.

In additional preferred embodiments, genotyping of arterial wall disruptive disorder can be performed by detecting a polymorphism in one or more of the following chromosomal regions, which are well known in the art for indicating a predisposition to macular degeneration: 1p21-q13, for recessive Stargardt's disease or fundus flavi maculatus (Allikmets, R. et al. *Science* 277:1805-1807, 1997; Anderson, K. L. et al., *Am. J. Hum. Genet.* 55:1477, 1994; Cremers, F. P. M. et al., *Hum. Mol. Genet.* 7:355-362, 1998; Gerber, S. et al., *Am. J. Hum. Genet.* 56:396-399, 1995; Gerber, S. et al., *Genomics* 48:139-142, 1998; Kaplan, J. et al., *Nat. Genet.* 5:308-311, 1993; Kaplan, J. et al., *Am. J. Hum. Genet.* 55:190, 1994; Martinez-Mir, A. et al., *Genomics* 40:142-146, 1997; Nasonkin, I. et al., *Hum. Genet.* 102:21-26, 1998; Stone, E. M.

et al., *Nat. Genet.* 20:321-329, 1998); 1q25-q31, for recessive age-related macular degeneration (Klein, M. L. et al., *Arch. Ophthalmol.* 116:1082-1088, 1988); 2p16, for dominant radial macular drusen, dominant Doyme honeycomb retinal degeneration or Malattia Leventinese (Edwards, A. O. et al., *Am. J. Ophthalmol.* 126:417-424, 1998; Heon, E. et al., *Arch. Ophthalmol.* 114:193-198, 1996; Heon, E. et al., *Invest. Ophthalmol. Vis. Sci.* 37:1124, 1996; Gregory, C. Y. et al., *Hum. Mol. Genet.* 7:1055-1059, 1996); 6p21.2-cen, for dominant macular degeneration, adult vitelliform (Felbor, U. et al. *Hum. Mutat.* 10:301-309, 1997); 6p21.1 for dominant cone dystrophy (Payne, A. M. et al. *Am. J. Hum. Genet.* 61:A290, 1997; Payne, A. M. et al., *Hum. Mol. Genet.* 7:273-277, 1998; Sokol, I. et al., *Mol. Cell.* 2:129-133, 1998); 6q, for dominant cone-rod dystrophy (Kelsell, R. E. et al. *Am. J. Hum. Genet.* 63:274-279, 1998); 6q11-q15, for dominant macular degeneration, Stargardt's-like (Griesinger, I. B. et al., *Am. J. Hum. Genet.* 63:A30, 1998; Stone, E.M. et al., *Arch. Ophthalmol.* 112:765-772, 1994); 6q14-q16.2, for dominant macular degeneration, North Carolina Type (Kelsell, R. E. et al., *Hum. Mol. Genet.* 4:653-656, 1995; Robb, M. F. et al., *Am. J. Ophthalmol.* 125:502-508, 1998; Sauer, C. G. et al., *J. Med. Genet.* 34:961-966, 1997; Small, K. W. et al., *Genomics* 13:681-685, 1992; Small, K. W. et al., *Mol. Vis.* 3:1, 1997); 6q25-q26, dominant retinal cone dystrophy 1 (Online Mendelian Inheritance in Man (TM). Center for Medical Genetics, Johns Hopkins University, and National Center for Biotechnology Information, National Library of Medicine. <http://www3.ncbi.nlm.nih.gov/omim> (1998); 7p21-p15, for dominant cystoid macular degeneration (Inglehearn, C. F. et al., *Am. J. Hum. Genet.* 55:581-582, 1994; Kremer, H. et al., *Hum. Mol. Genet.* 3:299-302, 1994); 7q31.3-32, for dominant tritanopia, protein: blue cone opsin (Fitzgibbon, J. et al., *Hum. Genet.* 93:79-80, 1994; Nathans, J. et al., *Science* 193:193-232, 1986; Nathans, J. et al., *Ann. Rev. Genet.* 26:403-424, 1992; Nathans, J. et al., *Am. J. Hum. Genet.* 53:987-1000, 1993; Weitz, C. J. et al., *Am. J. Hum. Genet.* 50:498-507, 1992; Weitz, C. J. et al., *Am. J. Hum. Genet.* 51:444-446, 1992); not 8q24, for dominant macular degeneration, atypical vitelliform (Daiger, S. P. et al., In 'Degenerative Retinal Diseases', LaVail, et al., eds. Plenum Press, 1997; Ferrell, R. E. et al., *Am. J. Hum. Genet.* 35:78-84, 1983; Leach, R. J. et al., *Cytogenet. Cell Genet.* 75:71-84, 1996; Sohocki, M. M. et al., *Am. J. Hum. Genet.* 61:239-241, 1997); 11p12-q13, for dominant macular degeneration, Best type (bestrophin) (Forsman, K. et al., *Clin. Genet.* 42:156-159, 1992; Graff, C. et al., *Genomics*, 24:425-434, 1994; Petrukhin, K. et al., *Nat. Genet.* 19:241-247, 1998; Marquardt, A. et al., *Hum. Mol. Genet.* 7:1517-1525, 1998; Nichols, B. E. et al., *Am. J. Hum. Genet.* 54:95-103, 1994; Stone, E. M. et al., *Nat. Genet.* 1:246-250, 1992; Wadeilus, C. et al., *Am. J. Hum. Genet.* 53:1718, 1993; Weber, B. et al., *Am. J. Hum. Genet.* 53:1099, 1993; Weber, B. et al., *Am. J. Hum. Genet.* 55:1182-1187, 1994; Weber, B. H.,

Genomics 20: 267-274, 1994; Zhaung, Z. et al., *Am. J. Hum. Genet.* 53:1112, 1993); 13q34, for dominant macular degeneration, Stargardt type (Zhang, F. et al., *Arch. Ophthalmol.* 112:759-764, 1994); 16p12.1, for recessive Batten disease (ceroid-lipofuscinosis, neuronal 3), juvenile; protein: Batten disease protein (Batten Disease Consortium, *Cell* 82:949-957, 1995; Eiberg, H. et al., *Clin. Genet.* 36:217-218, 1989; Gardiner, M. et al., *Genomics* 8:387-390, 1990; Mitchison, H. M. et al., *Am. J. Hum. Genet.* 57:312-315, 1995; Mitchison, H. M. et al., *Am. J. Hum. Genet.* 56:654-662, 1995; Mitchison, H. M. et al., *Genomics* 40:346-350, 1997; Munroe, P. B. et al., *Am. J. Hum. Genet.* 61:310-316, 1997; 17p, for dominant areolar choroidal dystrophy (Lotery, A. J. et al., *Ophthalmol. Vis. Sci.* 37:1124, 1996); 17p13-p12, for dominant cone dystrophy, progressive (Balciuniene, J. et al., *Genomics* 30:281-286, 1995; Small, K. W. et al., *Am. J. Hum. Genet.* 57:A203, 1995; Small, K. W. et al., *Am. J. Ophthalmol.* 121:13-18, 1996); 17q, for cone rod dystrophy (Klystra, J. A. et al., *Can. J. Ophthalmol.* 28:79-80, 1993); 18q21.1-q21.3, for cone-rod dystrophy, de Grouchy syndrome (Manhant, S. et al., *Am. J. Hum. Genet.* 57:A96, 1995; Warburg, M. et al., *Am. J. Med. Genet.* 39:288-293, 1991); 19q13.3, for dominant cone-rod dystrophy; recessive, dominant and 'de novo' Leber congenital amaurosis; dominant RP; cone-rod otx-like photoreceptor homeobox transcription factor (Bellingham, J. et al., In 'Degenerative Retinal Diseases', LaVail, et al., eds. Plenum Press, 1997; Evans, K. et al., *Nat. Genet.* 6:210-213, 1994; Evans, K. et al., *Arch. Ophthalmol.* 113:195-201, 1995; Freund, C. L. et al., *Cell* 91:543-553, 1997; Freund, C. L. et al., *Nat. Genet.* 18:311-312, 1998; Gregory, C. Y. et al., *Am. J. Hum. Genet.* 55:1061-1063, 1994; Li, X. et al., *Proc. Natl. Acad. Sci USA* 95:1876-1881, 1998; Sohocki, M. M. et al., *Am. J. Hum. Genet.* 63:1307-1315, 1998; Swain, P. K. et al., *Neuron* 19:1329-1336, 1987; Swaroop, A. et al., *Hum. Mol. Genet.* In press, 1999); 22q12.1-q13.2, for dominant Sorsby's fundus dystrophy (TIMP3) (Felbor, U. et al., *Hum. Mol. Genet.* 4:2415-2416, 1995; Felbor, U. et al., *Am. J. Hum. Genet.* 60:57-62, 1997; Jacobson, S. E. et al., *Nat. Genet.* 11:27-32, 1995; Peters, A. et al., *Retina* 15:480-485, 1995; Stöhr, H. et al., *Genome Res.* 5:483-487, 1995; Weber, B. H. F. et al., *Nat. Genet.* 8:352-355, 1994; Weber, B. H. F. et al., *Nat. Genet.* 7:158-161, 1994; Wijesvriya, S. D. et al., *Genome Res.* 6:92-101, 1996); and Xp11.4, for X-linked cone dystrophy (Bartley, J. et al., *Cytogenet. Cell. Genet.* 51:959, 1989; Bergen, A. A. B. et al., *Genomics* 18:463-464, 1993; Dash-Modi, A. et al., *Invest. Ophthalmol. Vis. Sci.* 37:998, 1996; Hong, H.-K., *Am. J. Hum. Genet.* 55:1173-1181, 1994; Meire, F. M. et al., *Br. J. Ophthalmol.* 78:103-108, 1994; Seymour, A. B. et al., *Am. J. Hum. Genet.* 62:122-129, 1998); all of which have been identified and characterized as harboring a polymorphism or mutation linked to macular degeneration; the above references are herein incorporated by. Thus, through the existence of polymorphisms in the art and of gene sequences of mutant alleles, the

art provides guidance ^{useful} for designing appropriate primer pairs ^{for performing} ~~performing~~ PCR for any particular mutant gene that causes or is associated with macular degeneration. By detecting macular degeneration in a subject or a genetic predisposition to macular degeneration, the subject's genetic predisposition to arterial wall disruptive disorder is also determined. In a preferred embodiment, the arterial wall disruptive disorder is AAA or TAAA and the macular degeneration is AMD of the DS/CNV type.

For example, information obtained using the diagnostic assays described herein (alone or in conjunction with information on another genetic defect, which contributes to the same disease) is useful for diagnosing or confirming that a symptomatic subject (e.g. a subject symptomatic for AMD), has a genetic defect (e.g. in an AMD-associated gene or in a gene that regulates the expression of a drusen-associated marker gene), which causes or contributes to the particular disease or disorder. Alternatively, the information (alone or in conjunction with information on another genetic defect, which contributes to the same disease) can be used prognostically for predicting whether a non-symptomatic subject is likely to develop a disease or condition, which is caused by or contributed to by an abnormal activity or protein level in a subject. Based on the prognostic information, a doctor can recommend a regimen (e.g. diet or exercise) or therapeutic protocol, useful for preventing or prolonging onset of the particular disease or condition in the individual.

In addition, knowledge of the particular alteration or alterations, resulting in defective or deficient genes or proteins in an individual (the genetic profile), alone or in conjunction with information on other genetic defects contributing to the same disease (the genetic profile of the particular disease) allows customization of therapy for a particular disease to the individual's genetic profile, the goal of "pharmacogenomics". For example, an individual's genetic profile or the genetic profile of a disease or condition, to which genetic alterations cause or contribute, can enable a doctor to 1) more effectively prescribe a drug that will address the molecular basis of the disease or condition; and 2) better determine the appropriate dosage of a particular drug. For example, the expression level of drusen-associated molecular marker proteins, alone or in conjunction with the expression level of other genes, known to contribute to the same disease, can be measured in many patients at various stages of the disease to generate a transcriptional or expression profile of the disease. Expression patterns of individual patients can then be compared to the expression profile of the disease to determine the appropriate drug and dose to administer to the patient.

The ability to target populations expected to show the highest clinical benefit, based on

profile marketed
the AAA/AMD genetic ~~le~~ can enable: 1) the repositioning of ~~eted~~ drugs with disappointing market results; 2) the rescue of drug candidates whose clinical development has been discontinued as a result of safety or efficacy limitations, which are patient subgroup-specific; and 3) an accelerated and less costly development for drug candidates and more optimal drug labeling (e.g. since the use of a drusen-associated molecular marker gene as a marker is useful for optimizing effective dose).

4.7 Transgenic animals

The invention further provides for transgenic animals, which can be used for a variety of purposes, e.g., to identify genetic loci involved in the common etiology of AAA and AMD, and, further, to create animal models for the treatment of AMD and AAA.

The transgenic animals can be animals containing a transgene, such as reporter gene, under the control of a drusen-associated marker gene promoter or fragment thereof. These animals are useful, e.g., for identifying drugs that modulate production of the drusen-associated molecular, such as by modulating vitronectin, Factor X, HLA-DR, IL-6 or elastin gene expression. A target gene promoter can be isolated, e.g., by screening of a genomic library with an appropriate cDNA fragment and characterized according to methods known in the art. In a preferred embodiment of the present invention, the transgenic animal containing a reporter gene is used to screen a class of bioactive molecules for their ability to modulate expression of a drusen-associated molecular marker such as a DRAM. Yet other non-human animals within the scope of the invention include those in which the expression of the endogenous target gene has been mutated or "knocked out". A "knock out" animal is one carrying a homozygous or heterozygous deletion of a particular gene or genes. These animals could be useful to determine whether the absence of the target will result in a specific phenotype, in particular whether these mice have or are likely to develop a specific disease, such as high susceptibility to AAA and/or AMD. Furthermore these animals are useful in screens for drugs which alleviate or attenuate the disease condition resulting from the mutation of the AAA/AMD-associated polymorphic gene as outlined below. These animals are also useful for determining the effect of a specific amino acid difference, or allelic variation, in a target gene. That is, the target knock out animals can be crossed with transgenic animals expressing, e.g., a mutated form or allelic variant of the target gene containing an AAA/AMD-associated polymorphic marker, thereby resulting in an animal which expresses only the mutated protein and not the wild-type target gene product.

obtaining animals
Methods for obtaining transgenic and knockout non-human animals are well known in the art. Knock out mice are generated by homologous integration of a "knock out" construct into a mouse embryonic stem cell chromosome which encodes the gene to be knocked out. In one embodiment, gene targeting, which is a method of using homologous recombination to modify an animal's genome, can be used to introduce changes into cultured embryonic stem cells. By targeting a specific gene of interest in ES cells, these changes can be introduced into the germ lines of animals to generate chimeras. The gene targeting procedure is accomplished by introducing into tissue culture cells a DNA targeting construct that includes a segment homologous to a target locus, and which also includes an intended sequence modification to the genomic sequence (e.g., insertion, deletion, point mutation). The treated cells are then screened for accurate targeting to identify and isolate those which have been properly targeted.

Gene targeting in embryonic stem cells is in fact a scheme contemplated by the present invention as a means for disrupting a target gene function through the use of a targeting transgene construct designed to undergo homologous recombination with one or more Target genomic sequences. The targeting construct can be arranged so that, upon recombination with an element of a Target gene, a positive selection marker is inserted into (or replaces) coding sequences of the gene. The inserted sequence functionally disrupts the Target gene, while also providing a positive selection trait. Exemplary targeting constructs are described in more detail below.

Generally, the embryonic stem cells (ES cells) used to produce the knockout animals will be of the same species as the knockout animal to be generated. Thus for example, mouse embryonic stem cells will usually be used for generation of knockout mice.

Embryonic stem cells are generated and maintained using methods well known to the skilled artisan such as those described by Doetschman et al. (1985) *J. Embryol. Exp. MoMFGFhol.* 87:27-45). Any line of ES cells can be used, however, the line chosen is typically selected for the ability of the cells to integrate into and become part of the germ line of a developing embryo so as to create germ line transmission of the knockout construct. Thus, any ES cell line that is believed to have this capability is suitable for use herein. One mouse strain that is typically used for production of ES cells, is the 129J strain. Another ES cell line is murine cell line D3 (American Type Culture Collection, catalog no. CKL 1934) Still another preferred ES cell line is the WW6 cell line (Ioffe et al. (1995) *PNAS* 92:7357-7361). The cells are cultured and prepared for knockout construct insertion using methods well known to the skilled artisan, such as those set forth by Robertson in: Teratocarcinomas and Embryonic Stem

Cells: A Practical Approach, E.J. Robertson, ed. IRL Press, Washington, D.C. [1987]); by Bradley et al. (1986) *Current Topics in Devel. Biol.* 20:357-371); and by Hogan et al. (Manipulating the Mouse Embryo: A Laboratory Manual, Cold Spring Harbor Laboratory Press, Cold Spring Harbor, NY [1986].

5 A knock out construct refers to a uniquely configured fragment of nucleic acid which is introduced into a stem cell line and allowed to recombine with the genome at the chromosomal locus of the gene of interest to be mutated. Thus a given knock out construct is specific for a given gene to be targeted for disruption. Nonetheless, many common elements exist among these constructs and these elements are well known in the art. A typical knock out construct
10 contains nucleic acid fragments of not less than about 0.5 kb nor more than about 10.0 kb from both the 5' and the 3' ends of the genomic locus which encodes the gene to be mutated. These two fragments are separated by an intervening fragment of nucleic acid which encodes a positive selectable marker, such as the neomycin resistance gene (neo^R). The resulting nucleic acid fragment, consisting of a nucleic acid from the extreme 5' end of the genomic locus linked
15 to a nucleic acid encoding a positive selectable marker which is in turn linked to a nucleic acid from the extreme 3' end of the genomic locus of interest, omits most of the coding sequence for the gene of interest to be knocked out. When the resulting construct recombines homologously with the chromosome at this locus, it results in the loss of the omitted coding sequence, otherwise known as the structural gene, from the genomic locus. A stem cell in which such a
20 rare homologous recombination event has taken place can be selected for by virtue of the stable integration into the genome of the nucleic acid of the gene encoding the positive selectable marker and subsequent selection for cells expressing this marker gene in the presence of an appropriate drug (neomycin in this example).

Variations on this basic technique also exist and are well known in the art. For
25 example, a "knock-in" construct refers to the same basic arrangement of a nucleic acid encoding a 5' genomic locus fragment linked to nucleic acid encoding a positive selectable marker which in turn is linked to a nucleic acid encoding a 3' genomic locus fragment, but which differs in that none of the coding sequence is omitted and thus the 5' and the 3' genomic fragments used were initially contiguous before being disrupted by the introduction of the
30 nucleic acid encoding the positive selectable marker gene. This "knock-in" type of construct is thus very useful for the construction of mutant transgenic animals when only a limited region of the genomic locus of the gene to be mutated, such as a single exon, is available for cloning and genetic manipulation. Alternatively, the "knock-in" construct can be used to specifically

functional

in a

eliminate a single functional domain of the targeted gene, resulting in a transgenic animal which expresses a polypeptide of the targeted gene which is defective in one function, while retaining the function of other domains of the encoded polypeptide. This type of "knock-in" mutant frequently has the characteristic of a so-called "dominant negative" mutant because, especially in the case of proteins which homomultimerize, it can specifically block the action of (or "poison") the polypeptide product of the wild-type gene from which it was derived. In a variation of the knock-in technique, a marker gene is integrated at the genomic locus of interest such that expression of the marker gene comes under the control of the transcriptional regulatory elements of the targeted gene. A marker gene is one that encodes an enzyme whose activity can be detected (e.g., β -galactosidase), the enzyme substrate can be added to the cells under suitable conditions, and the enzymatic activity can be analyzed. One skilled in the art will be familiar with other useful markers and the means for detecting their presence in a given cell. All such markers are contemplated as being included within the scope of the teaching of this invention.

As mentioned above, the homologous recombination of the above described "knock out" and "knock in" constructs is very rare and frequently such a construct inserts nonhomologously into a random region of the genome where it has no effect on the gene which has been targeted for deletion, and where it can potentially recombine so as to disrupt another gene which was otherwise not intended to be altered. Such nonhomologous recombination events can be selected against by modifying the abovementioned knock out and knock in constructs so that they are flanked by negative selectable markers at either end (particularly through the use of two allelic variants of the thymidine kinase gene, the polypeptide product of which can be selected against in expressing cell lines in an appropriate tissue culture medium well known in the art - i.e. one containing a drug such as 5-bromodeoxyuridine). Thus a preferred embodiment of such a knock out or knock in construct of the invention consist of a nucleic acid encoding a negative selectable marker linked to a nucleic acid encoding a 5' end of a genomic locus linked to a nucleic acid of a positive selectable marker which in turn is linked to a nucleic acid encoding a 3' end of the same genomic locus which in turn is linked to a second nucleic acid encoding a negative selectable marker. Nonhomologous recombination between the resulting knock out construct and the genome will usually result in the stable integration of one or both of these negative selectable marker genes and hence cells which have undergone nonhomologous recombination can be selected against by growth in the appropriate selective media (e.g. media containing a drug such as 5-bromodeoxyuridine for example).

Simultaneous selection ^{for the} positive selectable marker and ^{against the} negative selectable marker will result in a vast enrichment for clones in which the knock out construct has recombined homologously at the locus of the gene intended to be mutated. The presence of the predicted chromosomal alteration at the targeted gene locus in the resulting knock out stem cell line can be confirmed by means of Southern blot analytical techniques which are well known to those familiar in the art. Alternatively, PCR can be used.

Each knockout construct to be inserted into the cell must first be in the linear form. Therefore, if the knockout construct has been inserted into a vector (described *infra*), linearization is accomplished by digesting the DNA with a suitable restriction endonuclease selected to cut only within the vector sequence and not within the knockout construct sequence.

For insertion, the knockout construct is added to the ES cells under appropriate conditions for the insertion method chosen, as is known to the skilled artisan. For example, if the ES cells are to be electroporated, the ES cells and knockout construct DNA are exposed to an electric pulse using an electroporation machine and following the manufacturer's guidelines for use. After electroporation, the ES cells are typically allowed to recover under suitable incubation conditions. The cells are then screened for the presence of the knock out construct as explained above. Where more than one construct is to be introduced into the ES cell, each knockout construct can be introduced simultaneously or one at a time.

After suitable ES cells containing the knockout construct in the proper location have been identified by the selection techniques outlined above, the cells can be inserted into an embryo. Insertion may be accomplished in a variety of ways known to the skilled artisan, however a preferred method is by microinjection. For microinjection, about 10-30 cells are collected into a micropipet and injected into embryos that are at the proper stage of development to permit integration of the foreign ES cell containing the knockout construct into the developing embryo. For instance, the transformed ES cells can be microinjected into blastocytes. The suitable stage of development for the embryo used for insertion of ES cells is very species dependent, however for mice it is about 3.5 days. The embryos are obtained by perfusing the uterus of pregnant females. Suitable methods for accomplishing this are known to the skilled artisan, and are set forth by, e.g., Bradley et al. (*supra*).

While any embryo of the right stage of development is suitable for use, preferred embryos are male. In mice, the preferred embryos also have genes coding for a coat color that is different from the coat color encoded by the ES cell genes. In this way, the offspring can be

presence looking for
screened easily for the presence of the knockout construct by looking for mosaic coat color (indicating that the ES cell was incorporated into the developing embryo). Thus, for example, if the ES cell line carries the genes for white fur, the embryo selected will carry genes for black or brown fur.

5 After the ES cell has been introduced into the embryo, the embryo may be implanted into the uterus of a pseudopregnant foster mother for gestation. While any foster mother may be used, the foster mother is typically selected for her ability to breed and reproduce well, and for her ability to care for the young. Such foster mothers are typically prepared by mating with vasectomized males of the same species. The stage of the pseudopregnant foster mother is
10 important for successful implantation, and it is species dependent. For mice, this stage is about 2-3 days pseudopregnant.

Offspring that are born to the foster mother may be screened initially for mosaic coat color where the coat color selection strategy (as described above, and in the appended examples) has been employed. In addition, or as an alternative, DNA from tail tissue of the
15 offspring may be screened for the presence of the knockout construct using Southern blots and/or PCR as described above. Offspring that appear to be mosaics may then be crossed to each other, if they are believed to carry the knockout construct in their germ line, in order to generate homozygous knockout animals. Homozygotes may be identified by Southern blotting of equivalent amounts of genomic DNA from mice that are the product of this cross, as well as
20 mice that are known heterozygotes and wild type mice.

Other means of identifying and characterizing the knockout offspring are available. For example, Northern blots can be used to probe the mRNA for the presence or absence of transcripts encoding either the gene knocked out, the marker gene, or both. In addition, Western blots can be used to assess the level of expression of the Target gene knocked out in various
25 tissues of the offspring by probing the Western blot with an antibody against the particular Target protein, or an antibody against the marker gene product, where this gene is expressed. Finally, *in situ* analysis (such as fixing the cells and labeling with antibody) and/or FACS (fluorescence activated cell sorting) analysis of various cells from the offspring can be conducted using suitable antibodies to look for the presence or absence of the knockout
30 construct gene product.

Yet other methods of making knock-out or disruption transgenic animals are also generally known. See, for example, Manipulating the Mouse Embryo, (Cold Spring Harbor

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dependent

Laboratory Press, Cold Spring Harbor, N.Y., 1986). Recombinase ~~ndent~~ knockouts can also be generated, e.g. by homologous recombination to insert target sequences, such that tissue specific and/or temporal control of inactivation of a Target-gene can be controlled by recombinase sequences (described infra).

5 Animals containing more than one knockout construct and/or more than one transgene expression construct are prepared in any of several ways. The preferred manner of preparation is to generate a series of mammals, each containing one of the desired transgenic phenotypes. Such animals are bred together through a series of crosses, backcrosses and selections, to ultimately generate a single animal containing all desired knockout constructs and/or expression
10 constructs, where the animal is otherwise congenic (genetically identical) to the wild type except for the presence of the knockout construct(s) and/or transgene(s) .

 A Target transgene can encode the wild-type form of the protein, or can encode homologs thereof, including both agonists and antagonists, as well as antisense constructs. In preferred embodiments, the expression of the transgene is restricted to specific subsets of cells,
15 tissues or developmental stages utilizing, for example, cis-acting sequences that control expression in the desired pattern. In the present invention, such mosaic expression of a Target protein can be essential for many forms of lineage analysis and can additionally provide a means to assess the effects of, for example, lack of Target expression which might grossly alter development in small patches of tissue within an otherwise normal embryo. Toward this and,
20 tissue-specific regulatory sequences and conditional regulatory sequences can be used to control expression of the transgene in certain spatial patterns. Moreover, temporal patterns of expression can be provided by, for example, conditional recombination systems or prokaryotic transcriptional regulatory sequences.

 Genetic techniques, which allow for the expression of transgenes can be regulated via
25 site-specific genetic manipulation *in vivo*, are known to those skilled in the art. For instance, genetic systems are available which allow for the regulated expression of a recombinase that catalyzes the genetic recombination of a target sequence. As used herein, the phrase "target sequence" refers to a nucleotide sequence that is genetically recombined by a recombinase. The target sequence is flanked by recombinase recognition sequences and is generally either excised
30 or inverted in cells expressing recombinase activity. Recombinase catalyzed recombination events can be designed such that recombination of the target sequence results in either the activation or repression of expression of one of the subject Target proteins. For example, excision of a target sequence which interferes with the expression of a recombinant Target

encodes antisense
gene, such as one which encodes an antagonistic homolog or an antisense transcript, can be designed to activate expression of that gene. This interference with expression of the protein can result from a variety of mechanisms, such as spatial separation of the Target gene from the promoter element or an internal stop codon. Moreover, the transgene can be made wherein the coding sequence of the gene is flanked by recombinase recognition sequences and is initially transfected into cells in a 3' to 5' orientation with respect to the promoter element. In such an instance, inversion of the target sequence will reorient the subject gene by placing the 5' end of the coding sequence in an orientation with respect to the promoter element which allow for promoter driven transcriptional activation.

The transgenic animals of the present invention all include within a plurality of their cells a transgene of the present invention, which transgene alters the phenotype of the "host cell" with respect to regulation of cell growth, death and/or differentiation. Since it is possible to produce transgenic organisms of the invention utilizing one or more of the transgene constructs described herein, a general description will be given of the production of transgenic organisms by referring generally to exogenous genetic material. This general description can be adapted by those skilled in the art in order to incorporate specific transgene sequences into organisms utilizing the methods and materials described below.

In an illustrative embodiment, either the *cre/loxP* recombinase system of bacteriophage P1 (Lakso et al. (1992) *PNAS* 89:6232-6236; Orban et al. (1992) *PNAS* 89:6861-6865) or the FLP recombinase system of *Saccharomyces cerevisiae* (O'Gorman et al. (1991) *Science* 251:1351-1355; PCT publication WO 92/15694) can be used to generate *in vivo* site-specific genetic recombination systems. Cre recombinase catalyzes the site-specific recombination of an intervening target sequence located between *loxP* sequences. *loxP* sequences are 34 base pair nucleotide repeat sequences to which the Cre recombinase binds and are required for Cre recombinase mediated genetic recombination. The orientation of *loxP* sequences determines whether the intervening target sequence is excised or inverted when Cre recombinase is present (Abremski et al. (1984) *J. Biol. Chem.* 259:1509-1514); catalyzing the excision of the target sequence when the *loxP* sequences are oriented as direct repeats and catalyzes inversion of the target sequence when *loxP* sequences are oriented as inverted repeats.

Accordingly, genetic recombination of the target sequence is dependent on expression of the Cre recombinase. Expression of the recombinase can be regulated by promoter elements which are subject to regulatory control, e.g., tissue-specific, developmental stage-specific, inducible or repressible by externally added agents. This regulated control will result in genetic

target sequence

recombinase expression

recombination of the ~~target sequence~~ only in cells where ~~recombinase expression~~ is mediated by the promoter element. Thus, the activation expression of a recombinant Target protein can be regulated via control of recombinase expression.

Use of the *cre/loxP* recombinase system to regulate expression of a recombinant Target protein requires the construction of a transgenic animal containing transgenes encoding both the Cre recombinase and the subject protein. Animals containing both the Cre recombinase and a recombinant Target gene can be provided through the construction of "double" transgenic animals. A convenient method for providing such animals is to mate two transgenic animals each containing a transgene, e.g., a Target gene and recombinase gene.

One advantage derived from initially constructing transgenic animals containing a Target transgene in a recombinase-mediated expressible format derives from the likelihood that the subject protein, whether agonistic or antagonistic, can be deleterious upon expression in the transgenic animal. In such an instance, a founder population, in which the subject transgene is silent in all tissues, can be propagated and maintained. Individuals of this founder population can be crossed with animals expressing the recombinase in, for example, one or more tissues and/or a desired temporal pattern. Thus, the creation of a founder population in which, for example, an antagonistic Target transgene is silent will allow the study of progeny from that founder in which disruption of Target mediated induction in a particular tissue or at certain developmental stages would result in, for example, a lethal phenotype.

Similar conditional transgenes can be provided using prokaryotic promoter sequences which require prokaryotic proteins to be simultaneously expressed in order to facilitate expression of the Target transgene. Exemplary promoters and the corresponding trans-activating prokaryotic proteins are given in U.S. Patent No. 4,833,080.

Moreover, expression of the conditional transgenes can be induced by gene therapy-like methods wherein a gene encoding the trans-activating protein, e.g. a recombinase or a prokaryotic protein, is delivered to the tissue and caused to be expressed, such as in a cell-type specific manner. By this method, a TargetA transgene could remain silent into adulthood until "turned on" by the introduction of the trans-activator.

In an exemplary embodiment, the "transgenic non-human animals" of the invention are produced by introducing transgenes into the germline of the non-human animal. Embryonal target cells at various developmental stages can be used to introduce transgenes. Different methods are used depending on the stage of development of the embryonal target cell. The

can then be added to ^{the ovum} ~~th~~ or the decondensed sperm could be ^{added} ~~ed~~ to the ovum with the transgene constructs being added as soon as possible thereafter.

Introduction of the transgene nucleotide sequence into the embryo may be accomplished by any means known in the art such as, for example, microinjection, electroporation, or lipofection. Following introduction of the transgene nucleotide sequence into the embryo, the embryo may be incubated *in vitro* for varying amounts of time, or reimplanted into the surrogate host, or both. In vitro incubation to maturity is within the scope of this invention. One common method in to incubate the embryos in vitro for about 1-7 days, depending on the species, and then reimplant them into the surrogate host.

For the purposes of this invention a zygote is essentially the formation of a diploid cell which is capable of developing into a complete organism. Generally, the zygote will be comprised of an egg containing a nucleus formed, either naturally or artificially, by the fusion of two haploid nuclei from a gamete or gametes. Thus, the gamete nuclei must be ones which are naturally compatible, i.e., ones which result in a viable zygote capable of undergoing differentiation and developing into a functioning organism. Generally, a euploid zygote is preferred. If an aneuploid zygote is obtained, then the number of chromosomes should not vary by more than one with respect to the euploid number of the organism from which either gamete originated.

In addition to similar biological considerations, physical ones also govern the amount (e.g., volume) of exogenous genetic material which can be added to the nucleus of the zygote or to the genetic material which forms a part of the zygote nucleus. If no genetic material is removed, then the amount of exogenous genetic material which can be added is limited by the amount which will be absorbed without being physically disruptive. Generally, the volume of exogenous genetic material inserted will not exceed about 10 picoliters. The physical effects of addition must not be so great as to physically destroy the viability of the zygote. The biological limit of the number and variety of DNA sequences will vary depending upon the particular zygote and functions of the exogenous genetic material and will be readily apparent to one skilled in the art, because the genetic material, including the exogenous genetic material, of the resulting zygote must be biologically capable of initiating and maintaining the differentiation and development of the zygote into a functional organism.

The number of copies of the transgene constructs which are added to the zygote is dependent upon the total amount of exogenous genetic material added and will be the amount

genetic transformation

only one

which enables the ~~gene transformation~~ to occur. Theoretically, ~~one~~ copy is required; however, generally, numerous copies are utilized, for example, 1,000-20,000 copies of the transgene construct, in order to insure that one copy is functional. As regards the present invention, there will often be an advantage to having more than one functioning copy of each of the inserted exogenous DNA sequences to enhance the phenotypic expression of the exogenous DNA sequences.

Any technique which allows for the addition of the exogenous genetic material into nucleic genetic material can be utilized so long as it is not destructive to the cell, nuclear membrane or other existing cellular or genetic structures. The exogenous genetic material is preferentially inserted into the nucleic genetic material by microinjection. Microinjection of cells and cellular structures is known and is used in the art.

Reimplantation is accomplished using standard methods. Usually, the surrogate host is anesthetized, and the embryos are inserted into the oviduct. The number of embryos implanted into a particular host will vary by species, but will usually be comparable to the number of offspring the species naturally produces.

Transgenic offspring of the surrogate host may be screened for the presence and/or expression of the transgene by any suitable method. Screening is often accomplished by Southern blot or Northern blot analysis, using a probe that is complementary to at least a portion of the transgene. Western blot analysis using an antibody against the protein encoded by the transgene may be employed as an alternative or additional method for screening for the presence of the transgene product. Typically, DNA is prepared from tail tissue and analyzed by Southern analysis or PCR for the transgene. Alternatively, the tissues or cells believed to express the transgene at the highest levels are tested for the presence and expression of the transgene using Southern analysis or PCR, although any tissues or cell types may be used for this analysis.

Alternative or additional methods for evaluating the presence of the transgene include, without limitation, suitable biochemical assays such as enzyme and/or immunological assays, histological stains for particular marker or enzyme activities, flow cytometric analysis, and the like. Analysis of the blood may also be useful to detect the presence of the transgene product in the blood, as well as to evaluate the effect of the transgene on the levels of various types of blood cells and other blood constituents.

Progeny of the transgenic animals may be obtained by mating the transgenic

partner and/or animal with a suitable partner, or by *in vitro* fertilization of eggs and sperm obtained from the transgenic animal. Where mating with a partner is to be performed, the partner may or may not be transgenic and/or a knockout; where it is transgenic, it may contain the same or a different transgene, or both. Alternatively, the partner may be a parental line. Where *in vitro* fertilization is used, the fertilized embryo may be implanted into a surrogate host or incubated *in vitro*, or both. Using either method, the progeny may be evaluated for the presence of the transgene using methods described above, or other appropriate methods.

The transgenic animals produced in accordance with the present invention will include exogenous genetic material. As set out above, the exogenous genetic material will, in certain embodiments, be a DNA sequence which results in the production of a Target protein (either agonistic or antagonistic), and antisense transcript, or a Target mutant. Further, in such embodiments the sequence will be attached to a transcriptional control element, e.g., a promoter, which preferably allows the expression of the transgene product in a specific type of cell.

Retroviral infection can also be used to introduce transgene into a non-human animal. The developing non-human embryo can be cultured *in vitro* to the blastocyst stage. During this time, the blastomeres can be targets for retroviral infection (Jaenich, R. (1976) *PNAS* 73:1260-1264). Efficient infection of the blastomeres is obtained by enzymatic treatment to remove the zona pellucida (*Manipulating the Mouse Embryo*, Hogan eds. (Cold Spring Harbor Laboratory Press, Cold Spring Harbor, 1986). The viral vector system used to introduce the transgene is typically a replication-defective retrovirus carrying the transgene (Jahner et al. (1985) *PNAS* 82:6927-6931; Van der Putten et al. (1985) *PNAS* 82:6148-6152). Transfection is easily and efficiently obtained by culturing the blastomeres on a monolayer of virus-producing cells (Van der Putten, *supra*; Stewart et al. (1987) *EMBO J.* 6:383-388). Alternatively, infection can be performed at a later stage. Virus or virus-producing cells can be injected into the blastocoele (Jahner et al. (1982) *Nature* 298:623-628). Most of the founders will be mosaic for the transgene since incorporation occurs only in a subset of the cells which formed the transgenic non-human animal. Further, the founder may contain various retroviral insertions of the transgene at different positions in the genome which generally will segregate in the offspring. In addition, it is also possible to introduce transgenes into the germ line by intrauterine retroviral infection of the midgestation embryo (Jahner et al. (1982) *supra*).

A third type of target cell for transgene introduction is the embryonal stem cell (ES). ES cells are obtained from pre-implantation embryos cultured *in vitro* and fused with embryos

(Evans et al. (1981) *Nature* 292:154-156; Bradley et al. (1984) *Nature* 309:255-258; Gossler et al. (1986) *PNAS* 83: 9065-9069; and Robertson et al. (1986) *Nature* 322:445-448). Transgenes can be efficiently introduced into the ES cells by DNA transfection or by retrovirus-mediated transduction. Such transformed ES cells can thereafter be combined with blastocysts from a non-human animal. The ES cells thereafter colonize the embryo and contribute to the germ line of the resulting chimeric animal. For review see Jaenisch, R. (1988) *Science* 240:1468-1474.

4.9 Therapeutics

In another aspect, the invention provides methods for treating or preventing the development of arterial wall disruptive disorder in a subject by administering a pharmaceutically effective amount of a macular degeneration therapeutic. The macular degeneration therapeutic may be an anti-inflammatory agent, preferably an antagonists of TNF- α , IL-1, GM-CSF, IL-4 or IL-13. The therapeutic may also be IL-10, M-CSF, IL-6 and IL-4 or an agonist thereof. Any therapeutic that helps to decrease drusen formation or DS/CNV may be used, as it may also treat the concurrent arterial wall disruptive disorder. In a preferred embodiment, the agent is selected from the group consisting of cytokines, chemokines and agonists and antagonists thereof. Useful therapeutics include agents that inhibit inflammation.

In another embodiment, the macular degeneration therapeutic is an inhibitor of the expression of one or more DRAMs, such as, for example, amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, b2 microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin or vitronectin. In an another embodiment, the invention provides method for treating a drusen associated disease by modulating the production of DRAMs, e.g., inhibiting or antagonizing their gene expression or activity. The accumulation of amyloid P and α_1 -antichymotrypsin (an inhibitor of serine proteases) in drusen may act to counterbalance attempts by RPE or choroidal cells to clear drusen proteolytically. For example, amyloid P is also found in non-amyloid deposits associated with atherosclerosis (Niculescu, et al., 1987), keratin intermediate filament aggregates (Hintner, et al., 1988), and dense deposits associated with glomerulonephropathy (Yang, et al., 1992). It associates with elastic fibers and may function as a protease inhibitor *in vivo* (Li and McAdam, 1984; Vachino, et al., 1988). It is also a normal component of Bruch's membrane, where it might protect the elastic lamina against enzymatic degradation (Kivela, et al., 1994). The downregulation of the biosynthesis of these proteins is therefore important for inhibiting drusen formation or facilitating drusen clearance or resolution. Inhibiting of drusen formation or

clearance

by a number

facilitating drusen clearance or resolution may be accomplished by a number of regimes, such as (1) inhibition of RNA synthesis for one or more DRAMs, (2) enhancement of RNA turnover or degradation of one or more DRAMs, (3) inhibition of translation of RNA for one or more DRAMs into protein, (4) inhibition of protein processing or transport of one or more DRAMs; (5) inhibition of drusen formation by blocking particular protein binding sites on one or more factors which participate in inter- and intra-molecular binding necessary for the association of DRAMs which results in a drusen deposit; (6) digestion or perturbation of protein deposits (e.g., using enzymes); (7) targeting and destroying DRAMs *in situ* (e.g., using enzyme-antibody techniques). DRAMs may be targeted by using photoreactive laser therapy, for example, or other means for targeting and destroying a protein *in situ* which are well known in the art. Such means may include antibodies conjugated to a reactive group such as a protease or chemical substance which, when activated, cleaves or denatures the individual components or interferes with the interaction of two or more components.

In another embodiment, therapeutics for drusen-associated diseases include agents which alter the gene expression of factors that regulate the expression of one or more DRAMs. Such agents may be "antagonists" which inhibit, either directly or indirectly, DRAM biosynthesis. The agent may specifically inhibit the transcription or translation of a DRAM, for example. Alternatively, it may be preferable to upregulate either directly or indirectly a gene or genes which will increase the synthesis of a naturally occurring therapeutic agent. For example, the increased gene expression of a proteolytic enzyme that degrades one or more DRAMs or a cytokine or drug that modulates immune responses may be desired.

The invention is therefore also useful for monitoring the efficacy of a drusen therapeutic or preventative treatment, the absence of core formation, the disappearance of drusen or of a drusen core providing evidence of efficacy of the therapeutic or treatment.

In one aspect, the therapeutics of the invention relate to antisense therapy. As used herein, "antisense" therapy refers to administration or *in situ* generation of oligonucleotide molecules or their derivatives which specifically hybridize (e.g., bind) under cellular conditions, with the cellular mRNA and/or genomic DNA encoding one or more DRAMs so as to inhibit expression of that protein, e.g., by inhibiting transcription and/or translation. The binding may be by conventional base pair complementarity, or, for example, in the case of binding to DNA duplexes, through specific interactions in the major groove of the double helix. In general, "antisense" therapy refers to the range of techniques generally employed in the art, and includes any therapy which relies on specific binding to oligonucleotide sequences.

An antisense construct of the present invention can be defined, for example, as an expression plasmid which, when transcribed in the cell, produces RNA which is complementary to at least a unique portion of the cellular mRNA which encodes a DRAM protein. Alternatively, the antisense construct can be an oligonucleotide probe which is generated *ex vivo* and which, when introduced into the cell causes inhibition of expression by hybridizing with the mRNA and/or genomic sequences of a DRAM gene. Such oligonucleotide probes are preferably modified oligonucleotides which are resistant to endogenous nucleases, e.g., exonucleases and/or endonucleases, and are therefore stable *in vivo*. Exemplary nucleic acid molecules for use as antisense oligonucleotides are phosphoramidate, phosphothioate and methylphosphonate analogs of DNA (see also U.S. Patent Nos. 5,176,996, 5,264,564 and 5,256,775). Approaches to constructing oligomers useful in antisense therapy are well known in the art. With respect to antisense DNA, oligodeoxyribonucleotides derived from the translation initiation site, e.g., between the -10 and +10 regions of the drusen-associated component nucleotide sequence of interest, are preferred. Antisense approaches involve the design of oligonucleotides (either DNA or RNA) that are complementary to a DRAM mRNA, or their agonists or antagonists. The antisense oligonucleotides bind to the subject mRNA transcripts and prevent translation or promote degradation of the transcript. Absolute complementarity, although preferred, is not required. In the case of double-stranded antisense nucleic acids, a single strand of the duplex DNA may thus be tested, or triplex formation may be assayed. The ability to hybridize depends on both the degree of complementarity and the length of the antisense nucleic acid. Generally, the longer the hybridizing nucleic acid, the more base mismatches with an RNA it may contain and still form a stable duplex (or triplex, as the case may be). One skilled in the art can ascertain a tolerable degree of mismatch by use of standard procedures to determine the melting point of the hybridized complex.

Other features, strategies and methods of preparing and using antisense or ribozymes are found in U.S.S.N. 09/183,972, the teachings of which are incorporated herein by reference.

In another embodiment, the invention provides pharmaceutical compositions useful for treating or preventing arterial wall disruptive disorder, comprising an effective amount of a macular degeneration therapeutic and a therapeutically acceptable carrier. Such carriers and methods for preparing pharmaceutical preparations are found in U.S.S.N. 09/183,972, and are incorporated herein by reference.

In another aspect, the invention provides a method for identifying an agent for, or determining the efficacy of, an agent for treating or preventing arterial wall disruptive disorder

administering

dosage

in a subject by administering to a subject an agent at a non-toxic dosage and determining whether drusen formation or neovascularization is inhibited or has resolved. In another embodiment, the invention provides a method for identifying an agent for treating or preventing arterial wall disruptive disorder in a subject by contacting a non-human model for macular degeneration with an agent and monitoring one or more markers of macular degeneration, wherein the absence or disappearance of one or more of said markers is indicative of the inhibition of arterial wall disruptive disorder. As stated above, the marker may be monitored by any of a number of art known methods for detecting proteins or nucleic acids. The marker used to detect the macular degeneration can be the presence of drusen in the sub RPE space or one or more DRAMs, such as, for example, amyloid A protein, amyloid P component, antichymotrypsin, apolipoprotein E, b2 microglobulin, complement 3, complement C5, complement C5b-9 terminal complexes, factor X, fibrinogen, immunoglobulins (kappa and lambda), prothrombin, thrombospondin and vitronectin.

In yet another aspect, the invention provides animal models for AAA that may be used to diagnose AAA or test drugs directed at treating AAA but which also will treat AMD. Animal models for AMD provide therapies for regulating the clinical progression (or regression) of small AAAs. Example 4 provides a monkey model for AMD and therefore provides an animal model for AAA. Example 5 provides a rat model for AMD and therefore provides an animal model for AAA. Preferably any animal with a macula may be used to create an animal model.

The practice of the present invention will employ, unless otherwise indicated, conventional techniques of cell biology, cell culture, genetics, molecular biology, transgenic biology, microbiology, recombinant DNA, and immunology, which are within the skill of the art. Such techniques are described in the literature. See, for example, *Molecular Cloning A Laboratory Manual*, 2nd Ed., Sambrook, Fritsch and Maniatis (eds.) (Cold Spring Harbor Laboratory Press: 1989); *DNA Cloning*, Volumes I and II (D. N. Glover ed., 1985); *Oligonucleotide Synthesis* (M. J. Gait ed., 1984); Mullis et al. U.S. Patent No: 4,683,195; *Nucleic Acid Hybridization* (B. D. Hames & S. J. Higgins, eds., 1984); *Transcription And Translation* (B. D. Hames & S. J. Higgins, eds., 1984); *Culture Of Animal Cells* (R. I. Freshney, Alan R. Liss, Inc., 1987); *Immobilized Cells And Enzymes* (IRL Press, 1986); B. Perbal, *A Practical Guide To Molecular Cloning* (1984); the treatise, *Methods In Enzymology* (Academic Press, Inc., N.Y.); *Gene Transfer Vectors For Mammalian Cells* (J. H. Miller and M. P. Calos, eds., 1987, Cold Spring Harbor Laboratory); *Methods In Enzymology*, Vols. 154

and 155 (Wu et al., eds ~~immunochemical~~ *Methods In Cell And Molecular Biology* (Mayer and Walker, eds., Academic Press, London, 1987); *Handbook Of Experimental Immunology*, Volumes I-IV (D. M. Weir and C. C. Blackwell, eds., 1986); *Manipulating the Mouse Embryo*, (Cold Spring Harbor Laboratory Press, Cold Spring Harbor, N.Y., 1986); Rossner, B.,
5 *Fundamentals of Biostatistics*, Duxbury Press, Belmont, CA, 370-377, 199; Lewin, B., ed. *Genes VI*, Oxford University Press, UK, 1998.

Exemplification

Example 1: Abdominal Aortic Aneurysm/AMD Correlation: 1998 Database

10 A human repository consisting of more than 2000 pairs of human donor eyes (ranging in age from one day to 106 years), which have been processed within an average post-mortem time of 3.2 hours, was used to analyse the eyes for AMD. Medical and ocular histories, a family questionnaire, and blood and sera, were also obtained from most donors to determine the existence of AAA and AMD. Every eye was subjected to gross examination by a retinal specialist and processed for light (4% paraformaldehyde) and electron (2.0% formaldehyde and
15 2.5% glutaraldehyde) microscopy, immunohistochemistry, and various biochemical and molecular biological analyses, known in the art. Thus, DNA, RNA, fixed and frozen tissues were available for every eye in the repository. In addition, RPE cell lines were established and frozen from selected donors of all ages and races, with and without AMD. Approximately 18% of the eyes in the collection exhibit distinguishing signs of AMD (disciform scars, submacular neovascular membranes, abnormal pigmentation, and/or geographic atrophy) and/or a clinically
20 documented history of AMD. Other ocular and systemic diseases including glaucoma, diabetes, other retinal and macular degenerations, Alzheimer's disease, Parkinson's disease, and a variety of developmental anomalies are also represented in the repository. The donor eye repository is useful for the study of specific biological processes involved in the etiology of
25 AMD, genotype-phenotype correlations, and "candidate" molecules and genes associated with the etiology of AMD and other macular dystrophies.

Eyes from the 1998 repository will serve as an example. This database was selected because medical records of the donors was the most comprehensive. Of 207 total donors obtained in the year 1998 ("The 1998 Database"), 33 had AMD (15.9% of total) and 12 donors
30 had AAA (5.8% of total). Of the 33 AMD donors 4 had geographic atrophy (GA, which is characteristic of the dry form of AMD) (1.9% of total), 11 had disciform scars and choroidal neovascularization (DS/CNV, which is characteristic of the wet form of AMD) (5.3% of total),

AMD in distinguish between
and 18 others had AMD which the diagnosis did not distinguish between the wet or dry form
(8.7% of total) (Table 2).

Of the 207 total donors 12 donors had AAA. Of those 12 AAA donors 8 also had AMD
(66.7% of AAA donors). Of the 8 donors with AMD 6 had the DS/CNV form (50% of AAA
donors) and 2 had the GA form (16.7%). (Table 2). Tables 3 and 4 present an analysis of the
studies and provide expected and observed occurrences and co-occurrences of AAA and AMD
that prove that the two diseases are at a 10-fold greater frequency than would be expected of the
total population:

Table 2: Summary of Data of Eye Donors having AAA and / or AMD and / or DS/CNV

207 Total Donors

33 Donors had AMD =

4 Geographic Atrophy (GA)

11 Disciform scar and choroidal neovascularization (DS/CNV)

18 Other/unknown

12 Donors had AAA:

8 AMD (= 6 DS/CNV and 2 GA)

% of 1998 database w/AMD: 15.9%

% of 1998 database w/DS/CNV: 5.3%

% of 1998 database w/AAA: 5.8%

% of AAA donors w/AMD: 66.7%

% of AAA donors w/DS/CNV: 50%

Table 3: Prevalence of AAA and / or AMD

	AMD-	AMD+	Total:
AAA±	4	8	12
AAA-	170	25	195

- a) For donors with clinically diagnosed AMD, what are chances of also having AAA?

AAA in entire repository: 12/207 (5.8%)

5 AAA in donors w/o AMD: 4/174 (2.3%)

AAA in donors with AMD: 8/33 (24%)

	<u>DS/CNV-</u>	<u>DS/CNV+</u>	<u>Total:</u>
10 AAA+	6	6	12
AAA-	190	5	195
Totals: 196	11	207	

- 15 b) For AMD donors with DS/CNV, what are chances of also having AAA?

AAA in entire repository: 12/207 (5.8%)

AAA in donors w/o DS/CNV: 6/196 (3.1%)

AAA in donors with DS/CNV: 6/11 (54.5%)

- 20 Table 4: Observed and Expected AMD, CNV/DS and AAA

	<u>Obs. AMD+</u>	<u>Exp. AMD+</u>	<u>Obs. AMD-</u>	<u>Exp. AMD-</u>
AAA+	8	1.91 ^a	4	10.09 ^c

	<u>Obs. AAA+</u>	<u>Exp. AAA+</u>	<u>Obs. AAA-</u>	<u>Exp. AAA-</u>
AMD+8		1.91 ^a	25	31.09 ^d

	<u>Obs. DS/CNV+</u>	<u>Exp. DS/CNV+</u>	<u>Obs. DS/CNV-</u>	<u>Exp. DS/CNV-</u>
5 AAA+ 6		0.64 ^b	6	11.36 ^c

Wherein: Obs.=Observed; Exp.=Expected;

a) Exp. AMD+/AAA+=(%AMD+in total)(%AAA+in total)(total donors)=(15.9%)(5.8%)(207)=1.91

b) Exp. DS/CNV+/AAA+=(%CNV+ in total)(%AAA+in total)(total donors)= (5.3%)(5.8%)(207)=0.64

10 c) Exp. AMD-/AAA+= total AAA(+) - Exp.AMD+/AAA+ = 12-1.91 = 10.09

d) Exp. AAA-/AMD+= total AMD(+) - Exp. AAA+/AMD+ = 33-1.91= 31.09

e) Exp. DS/CNV-/AAA+= total AAA(+) - Exp.DS/CNV+/AAA+ = 12 - 0.64 = 11.36

Results:

15 Table 4 demonstrates that the co-occurrence of DS/CNV with AAA is 9.4 fold higher than that expected from the above population of 207 human donors. The co-occurrence of AMD with AAA is 4.2 fold higher than that expected from the above population of 207 human donor eyes. A statistical analysis of the co-occurrence of two variables was determined by the Fisher's exact test (Rossner, B., *Fundamentals of Biostatistics*, Duxbury Press, Belmont, CA, 20 370-377, 1995). For Fisher's exact test of co-occurrence of AAA and DS/CNV, $p<.00001$. This is a statistically significant correlation of the incidence of AMD with that of AAA, suggesting that the diseases share etiology or the same genetic locus.

Example 2: Incidence of AMD in Thoracic Aortic Aneurysm

25 Of 207 human donors obtained according to Example 1, 8 donor eyes had thoracic aorticanneurysm (TAA), all of which had AMD-associated fundus findings. One TAA donor also had AAA with DS/CNV.

Example 3: Pathologies associated with AMD

A database is provided describing the medical conditions identified in a database appended hereto as Table 5. A human repository consisting of donor eyes has been collected according to the parameters specified in Example 1. Medical and ocular histories, a family questionnaire, and blood and sera, were also obtained from most donors to determine the existence of AAA and AMD. Every eye was subjected to gross examination by a retinal specialist and processed for light (4% paraformaldehyde) and electron (2.0% formaldehyde and 2.5% glutaraldehyde) microscopy, immunohistochemistry, and various biochemical and molecular biological analyses, known in the art. Thus, DNA, RNA, fixed and frozen tissues were available for every eye in the repository. In addition, RPE cell lines were established and frozen from selected donors of all ages and races, with and without AMD. Eyes were analyzed for the presence of AMD by direct examination (disciform scars, submacular neovascular membranes, abnormal pigmentation, and/or geographic atrophy) or by obtaining a clinically documented history of the condition. Other ocular and systemic diseases including glaucoma, diabetes, other retinal and macular degenerations, Alzheimer's disease, Parkinson's disease, and a variety of developmental anomalies are also represented in the repository. The donor eye repository is useful for the study of specific biological processes involved in the etiology of AMD, genotype-phenotype correlations, and "candidate" molecules and genes associated with the etiology of AMD and other macular dystrophies.

Example 4: Monkey Model of AAA

A preferred animal model is an animal with a macula, such a monkey. For example a cynomolgus monkey was anesthetized according to methods well known in the art. The choroidal circulation was blocked and a 360° peritomy was made and traction sutures were used to rotate the eye as far as possible supinasally to gain access to the posterior globe. A blunt cannula was used to separate the choroid from the edge of the sclera and 100µl of sterile balanced salt solution (BSS) containing 60 units of protease-free chondroitinase ABC (American Cyanimide) was injected into the choroidal stroma. The sclerotomy was closed with 7-0 vicryl sutures. Indirect ophthalmoscopy demonstrated a normal choroid and retina without hemorrhage or depigmentation. The conjunctiva was closed with 7-0 vicryl suture and 3mg celestone was injected subconjunctivally. The animal was monitored non-invasively with an ophthalmoscope to monitor fundus changes, including neovascularization, for 7 days. The

TABLE 5

DONOR	AAA	AMD	AO STENOSIS	GLAUCOMA	CAUSE OF DEATH	MEDICAL HISTORY
004-97		X			pneumonia	CVA,M, GI bleed, CHF, COPD
19-97	X				1-resp. failure 2-COPD	abdominal aneurysm
26-97			X		1- cardiac arr. 2-rup. TAA	RF, AVR
31-97			X		1-CPA 2-CHD	congenital heart valve defects
34-97		X			CHF	CHF, COPD
38-97		X			MSF	HTN, CHF
39-97		X			1 R/A 2-COPD	RF, COPD
43-97		X ?			end stage COPD	CHF, pneumonia
60-97	TAA				ruptured thoracic aneurysm	pre-systemic CA
62-97		X ?			COPD	COPD, mild dementia, aspiration
87-97	X				ICB	CHF, CAD, HTN, heart disease
96-97			X		MI	CHF, IDDM, RNF
100-97		X			MI	CPA
102-97				X	ICB	TIAs, seizure disorders
109-97		X		X	CHF	?
110-97		X ?			?	?
111-97		X		X	CVA	HTN, CAD
113-97		X			probable MI	CPA
125-97		X			cardiomyopathy, sepsis	CHF, cardiomyopathy, glomerulonephritis
132-97		X			GI bleed	HTN, GI bleed, biat hip fx
117-97	X				CPA	COPD, dementia
136-97		X			MI	?
145-97		X ?			cardiac arrest	IDDM, diabetes
150-97		X ?			sepsis, pneumonia	?
152-97		X ?			pulmonary fibrosis	prostatic HTN, pulm. HTN, interstitial pulm. infiltrates
161-97		X ?			MI	CHF, cellulitis in legs
154-97		X F			CHF, HM	?
160-97				X F/D	ICB	HTN, Alzheimer's
162-97		X			COPD	CHF, COPD, MI
172-97	X				MI	AAA repair
173-97				X	ruptured AAA	a-fib, hypothyroidism
174-97	X	X		X	ruptured AAA	CAD, peripheral vascular disease
181-97			X		Promyelocytic leukemia	FABM3, CVA, ARDS, HTN
182-97		X F			MI	HTN, CHF, Type II diabetes
189-97	X ?	X			CHF, stroke	CHF, CAD, HTN, heart disease

TABLE 5

DONOR	AAA	AMD	AO STENOSIS	GLAUCOMA	CAUSE OF DEATH	MEDICAL HISTORY
191-97		X F			1-scleroderma 2-pulm fibr.	?
192-97		X			Prostrate CA	MI
193-97		X F/D			MI	heart disease
001-98			X		sepsis, colon CA	COPD, renal CA
002-98		X			ICB	CHF with pulmonary disease
005-98		X			uterine CA	aortic valve malfunction, HTN, CHF
007-98		X			CAD	MI, stenosis, CAD, HTN
010-98		X			lung CA	HTN, COPD, CHF
011-98		X			pneumonia	CHF, CAD, COPD, a-fib
16-98		X		X	CHF	?
22-98		X			pneumonia	?
25-98		X F			CVA	IDDM, HTN, CAD, nephritis, stroke
27-98	X ?				resp. fail., pulm. fibrosis	HTN, chronic a-fib, TIA, CAD, CABG/aortic bypass
30-98		X ?			heart failure	?
35-98		X		X	Respiratory arrest	Bronchiectasis, HTN
38-98				X	MI	?
40-98	X				CVA	MI, weakness with CVA
44-98		X			CHF	CAD, CABG, COPD, CHF, cardiomyopathy
46-98		X			septic shock	CVA, CHF, IDDM, breast CA
51-98		X			1-resp. fail. 2-pneumonia	CHF, HTN, emphysema
52-98		X F			RF	IDDM, a-fib, hypothyroidism
55-98		X			lung CA	pneumonia, diabetes
58-98		X		X	colon CA	HTN
59-98		X			aspiration pneumonia	MI, ASHD
61-98		X			MI	pneumonia, atherosclerosis
63-98		X			gangrenous bowel	?
66-98				X	bowel obstruction	CVA, HTN, diabetes
67-98			X		1-resp. fail. 2-pneumonia	HTN, hypoxia, a-fib, ventricular tachycardia
68-98		X	X		CVA, CHF	valvular heart disease, HTN
70-98		X F/D		X	MI, CHF	MI, severe CAD with CABG, CHF, IDDM, pulmonary HTN
72-98	X				ruptured AAA	HTN, emphysema
77-98	X				aortic dissection	HTN, COPD, pulmonary HTN
83-98		X F			GI bleed, sepsis	?
85-98		X			CHF	stroke, HTN
90-98		X	X		MI	CAD, HTN, mitral valve prolapse
94-98		X			RF	HTN, IDDM, PVD, psoriasis

TABLE 5

DONOR	AAA	AMD	AO STENOSIS	GLAUCOMA	CAUSE OF DEATH	MEDICAL HISTORY
95-98			X		CVA	ASHD,CVA,degenerative arthritis
99-98				X	lung CA	a-fib,CAD,CHF,IDDm,MI
105-98		X			lung CA	COPD,HTN,a-fib,pneumonia
107-98		X F			pneumonia	COPD, lung CA, RF, anemia
116-98		X			CHF	CHF, COPD, pulmonary embolism
117-98		X ?			breast CA	HTN
136-98		X			MI	prostite CA
137-98		X			pneumonia	HTN,MI
139-98		X			probable MI	?
141-98				X ?	stroke,CVA	stroke,IDDm,a-fib,HTN,CVA,carotid sleat,angioplasty
142-98				X	CVA	dementia,multiple CVA
148-98		X F			lung CA	lobectomy stroke,PVD,HTN,DVT
149-98		X			CAD	CAD,COPD,MI,renal insufficiency,diverticulosis
150-98		X			leukemia	HTN,colon CA, bone CA
151-98		X F			1-septic shock 2-leukemia	leukemia
153-98		X			1-septic shock 2-lymphoma	DM,ASCVD,CVA,a-fib,CHF,RF
157-98		X F/D			heart disease	HTN,heart disease
159-98	X	X ?			pontine bleed	HTN,CABG,emphysema,heart disease,AVR,asecnd,AAA
160-98			X		pulmonary embolism	COPD
161-98		X			1-sepsis 2-CHF	HTN,PVD,CHF,RNF,chronic a-fib
166-98				X	MSF	dementia
168-98		X F/D			RF,sepsis	ARF,HTN,pneumonia
169-98			X		severe anemia	?
175-98	X	X			1-pneumonia 2-resp. arr.	PVD,SOB,CAD,COPD,GI bleed,chronic anemia
182-98		X			1-COPD 2-CAD	COPD,CAD,s/p inferior myocardial
185-98		X F/D		X F	1-pneumonia 2-renal CA	HTN,heart disease,respiratory insufficiency
186-98	X F/D	X			MI	MI,CAD,CABG
194-98	X	X			1-COPD 2-PVD	IDDm,HTN,COPD,CRF
196-98		X			RF	colon polyps,MI,HTN,diabetes,atherosclerosis
197-98		X F			RNF	leukemia,pneumonia
207-98	X				ruptured AAA	MI,RF
216-98			X		1-MI 2-GI bleed	HTN,MI,ASHD,COPD
226-98		X ?			lung CA	lung CA with mets
233-98			X		perforated ulcer	HTN,diabetes,non-specific left colitis
238-98	X				1-MI 2-spinal infaret	MI,stroke
239-98	TAA				CHF	a-fib,HTN,thoracic aortic aneurysm,deg. joint disease

TABLE 5

DONOR	AAA	AMD	AO STENOSIS	GLAUCOMA	CAUSE OF DEATH	MEDICAL HISTORY
256-98	X				post CABG, comps with CVA	HTN, COPD, 2X pulmonary embolus, aortic dissection
278-98	X				AAA	CAV with aphasia, myocardia ischemia
280-98		X ?			?	IDDM, HTN, PVD, renal insufficiency
284-98		X	X		severe COPD	CHF, breast CA, aortic valve disorder
006-99					CHF, MI, diabetes	IDDM, CHF, cardiomyopathy
010-99	X	X ?		X ?	CHF	MI, COPD, HTN, I ventricle hypertrophy
16-99	TAA				1-resp. arr. 2-end st. COPD	COPD, CHF, ascending thoracic aortic aneurysm
21-99	X				pneumonia	HTN, COPD
24-99		X ?			aortic iliac thrombosis	HTN, CAD, PVD, RF, CHF, MI
27-99		X ?			AML	HTN, leukemia
30-99	X F				?	HTN
31-99	X				failed repair AAA	HTN, ASHD, CAB
32-99	X			X	ruptured AAA	COPD
33-99		X			MI	hypokalemia
39-99	X				ruptured AAA	HTN, CHF, COPD, Type II IDDM
40-99		X			CVA	early AMD/CMA, PVD, IDDM, CHF, HTN
43-99			X		1-pneumonia 2-lupus	CVA, hypoglycemia
44-99		X	X		chronic congenital cirrhosis	non-exudate AMD
48-99			X		ischemic bowel	CHF, HTN, COPD, DVT
59-99		X			lymphoma	HTN
60-99		X		X	Asystole	?
70-99		X ?			CVA	CABG, I perial stroke
75-99		X			1-sepsis 2-Prostate CA	prostate CA, non-exudate AMD
79-99		X F/D			sepsis, perforated divertic.	HTN, MI, CAD
80-99		X F			MSF	?
81-99				X ?	?	prostate CA, MI
85-99		X ?			lung CA with mets	ASCVD, MI, I ventricular hypertrophy
91-99		X F/D			lung CA with mets	leukemia, CAD, IHD
98-99		X			end stage COPD	COPD, HTN, mild CHF, CAD
99-99	X	X			lymphocytic leukemia	ruptured AAA, HTN, dry AMD
101-99			X		?	L carotid stenosis, COPD, AODM with retinopathy
113-99	X	X F			1-resp. failure 2-COPD	COPD, HTN, anterior MI
114-99		X			Stroke(CVA)	HTN, CVA, dry AMD
130-99		X			COPD	HTN, CHF, COPD, supraventricular tachycardia
133-99	X			X	1-MSF 2-AAA	CAD, PVD, COPD, supraventricular tachycardia
138-99	X F/D				hemorrhage post CAB	COPD, CAD, CHF?

animal was then ^{ethanized} euthanized with barbiturate overdose ("Sleepaway") and the eyes prepared for histological observation according to art known methods. Distinct disruptions of Bruch's membrane were observed in the experimental eye, demonstrating that the enzyme reached Bruch's membrane.

5 The above example can be modified to inject 1-100 U/ml elastase in 0.05 to 0.50 ml BSS.. Alternatively, the method described above can be modified to replace the injection of enzyme for the insertion of enzyme in the form of a slow release pellet, such slow release pellet technology being well known in the art. Alternatively, the aorta may be perfused with elastase or chondroitinase, without the need for surgery, and the animal monitored as above.

10 **Example 5: Rat Model for AAA**

Anidjar/Dobrin rat is created by the infusion of the abdominal aorta with pancreatic elastase. (Anidjar, S., et al., *Circulation*, 82:973-981, 1990, the teachings of which are incorporated herein by reference and described briefly below). In short, a 1 cm segment of the abdominal aorta of a male Wistar rat is isolated and perfused. The animals are anesthetized with 6% sodium pentobarbital (0.1 ml/100g body weight) and a PE10 polyethylene catheter is inserted into the femoral artery under a binocular surgical microscope until the tip reaches the infrarenal abdominal aorta. The vena cava is dissected free from the aorta by laparotomy, collateral arteries ligated and the position of the catheter tip verified. The abdominal aorta is clamped at the level of the left renal vein and ligated around the catheter 1 cm downstream. This isolated segment of abdominal aorta is then perfused with 2ml of the appropriate test solution (rate, 1 ml/hr), such as 15 units pancreatic elastase (Type I; 1 unit=1 mg elastin hydrolysed for 20 minutes at pH8.8, 37°C, Sigma Chemical Co., St. Louis, MO) in 2 mls normal saline from the lumen to the adventitia through the media. Control rats are perfused with 2 ml saline alone. At the end of the perfusion, the aorta is unclamped, the ligature and the catheter removed, the femoral artery ligated and the aortic permeability verified. The wounds are closed and the rats are returned to their cages and monitored for the presence of AMD (e.g., drusen, disciform scars or choroidal neovascularization) and for AAA.

Alternatively, the rat may be perfused with other proteases such as collagenase, papain, trypsin, chymotrypsin, chondroitinase, plasmin, plasminogen activator or any other protease that has "elastase activity" (i.e., it can solubilize mature cross-linked elastin) or elastolytic protease (e.g., macrophage or neutrophil derived proteases). The perfusion of thioglycollate or

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trypsin, chymotrypsin, ^{chondroitinase} ~~chondroitinase~~, plasmin, plasminogen ^{activator} ~~acti~~ or any other protease that has "elastase activity" (i.e., it can solubilize mature cross-linked elastin) or elastinolytic protease (e.g., macrophage or neutrophil derived proteases). The perfusion of thioglycollate or other inflammatory stimulus would also induce an inflammatory response in the aorta, thereby exacerbating the AAA or AMD effect.

The Anidjar/Dobrin rat may alternatively be infused with elastin degradation products (EDPs) which have been shown to weaken the aorta and to be chemotactic for dendritic cells and macrophages. For example, the peptide Val-Gly-Val-Ala-Pro-Gly ^(SEQ ID NO: 1) can be injected into the aorta and the dilation of the aorta monitored. (Senior, R. M. et al., *J. Cell Biol.*, 99:870-874, 1984). This rat may be used to monitor the effects of agents that inhibit the infiltration of immune cells to damaged aortas (e.g., caused by EDPs), for example, antibodies directed at CD18, a pan-leukocyte antigen, which block the migration of macrophages which contribute to dissection. (Ricci, M. A. et al., *J. Vasc. Surg.*, 23:301-307, 1996).

Example 6: Drusen Associated with Aging and Age-Related Macular Degeneration Contain Proteins Common to Extracellular Deposits Associated with Atherosclerosis, Elastosis, Amyloidosis, and Dense Deposit Disease:

Recent studies in this laboratory revealed that vitronectin is a major component of drusen. Because vitronectin is also a constituent of abnormal deposits associated with a variety of diseases, drusen from human donor eyes were examined for compositional similarities with other extracellular disease deposits. The sixty-three human donor eyes employed in this study were obtained from The University of Iowa Lions Eye Bank (Iowa City, IA) within four hours of death; donor ages ranged from 45 to 96 years. Drusen were categorized as hard or soft. Tissues from a minimum of five donors were assayed with each antibody employed, at least two of whom had clinically-documented AMD, and each drusen phenotype was examined in at least two donors. Institutional Review Board committee approval for the use of human donor tissues was obtained from the Human Subjects Committee at The University of Iowa. Thirty-four antibodies to twenty-nine different proteins or protein complexes were tested for immunoreactivity with hard and soft drusen phenotypes. These analyses provide a partial profile of the molecular composition of drusen (see Table A below). Serum amyloid P component, apolipoprotein E, immunoglobulin light chains, Factor X, and complement proteins (C5 and C5b-9 complex) were identified in all drusen phenotypes. Transcripts encoding a

the retina

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Table A: Immunoreactivity of Drusen

Antigen	Supplier	Conc.	No.	Drusen
Albumin	Accurate	1:50	5	-
Amyloid A	Dako	1:50	8	+/-; vesicles
Amyloid β	Dako	1:10	7	-
Amyloid Precursor Protein	Boehringer Mannheim	1:20	5	-
Amyloid P component	Dako	1:50	6	++
	Calbiochem	1:50	5	++
α 1-antichymotrypsin	Dako	1:50	6	+/- (var.)
	Calbiochem	1:50	5	+/- (var.)
α 1 anti-trypsin	ICN	1:50	5	-, rare +/-
Apolipoprotein A1	Calbiochem	1:50	6	-
Apolipoprotein B	Chemicon	1:20	6	-
	Dako	1:50	5	- to +/-
Apolipoprotein E	Calbiochem	1:50	9	+
Atrial natriuretic factor	Chemicon	1:50	5	-
C-reactive protein	Dako	1:50	5	- to +/-, (var.)
Calcitonin	Dako	1:50	5	-
Complement C1q	Calbiochem	1:50	5	-
Complement C3	Dako	1:50	5	- to +, (var.)
Complement C5	Dako	1:50	5	++
Complement C5b-9	Dako	1:50	5	++
Cystatin C	Accurate	1:50	5	-, (var.)
Factor X	Dako	1:50	9	+
Fibrinogen	Dako	1:50	5	- to +/-, (var.)
Gelsolin	Chemicon	1:50	5	-
HLA-DR	Accurate	1:25	10	+
	Dako	1:200	10	+
Immunoglobulin kappa	Boehringer Mannheim	1:50	8	- to +/-
Immunoglobulin lambda	Dako	1:50- 1:2000	9	+/- to +
β 2 microglobulin	Boehringer Mannheim	1:50	5	- to +/-
Prothrombin	Dako	1:50	5	+ (vesicles)
Tau	Dako	1:50	5	-
Transthyretin	Boehringer Mannheim	1:50	9	+/- (var.)
Ubiquitin	Chemicon	1:50	5	-
	StressGen	1:100	5	-, rare +/-

Key: ++ = intense, invariant labeling; + = strong labeling in most donors; +/- = weak labeling; - = no labeling detected; (var.) = donor to donor or drusen to drusen variation; vesicles = labeling of spherical profiles within drusen

Table B: RT-PCR results from retina, RPE/choroid, and liver.

Gene Name	Primer Sequence (SEQ ID NOS: 2-25)	Ret	R/Ch	RPE	Gen	Liver
Albumin	SN 5' GTCGAGATGCACACAAGAGTG 3' AS 5' TCCTTCAGTTTACTGGAGATCG 3'	+	+	+	-	+
Amyloid P	SN 5' GCCAGGAATATGAACAAGCCG 3' AS 5' CAAATCCCCAATCTCTCCAC 3'	-	-	-	-*	+
Apo B	SN 5' TGAACACCAACTTCTTCCACG 3' AS 5' GCGACCTCAGTAATTTTCTTG 3'	+	+	-	-	+
Apo E	SN 5' GGTCGCTTTTGGGATTACC 3' AS 5' CTCCAGTTCCGATTGTAGGC 3'	+	+	+	-	+
Complement 3	SN 5' GTTCAAGTCAGAAAAGGGGC 3' AS 5' GTGTCTTGGTGAAGTGATCTG 3'	+	+	+	-	+
Complement 5	SN 5' ATGGTATGTGGACGATCAAGGC 3' AS 5' TATTGCTCGGTAACCTTCCCTG 3'	+	+	+	-	+
Complement 9	SN 5' AATGAGCCCCTGGAGTGAATG 3' AS 5' ATGTCAGAGTGTTCATCCCG 3'	+	+	-	-	+
Factor X	SN 5' GAGCGAGTTCTACATCCTAACG 3' AS 5' CACGAAGTAGGTGTCCTTGAAG 3'	+	+	-	-	+
Fibrinogen	SN 5' AGACTGGAATAACAAATGCCC 3' AS 5' AGATTCAGAGTGCCATTGTCC 3'	-	+	-	-	+
Ig kappa	SN 5' ACGTTTGATITCCASYTTGGTCCC 3' AS 5' GAMATYSWGIATGACICAGTCTCC 3'	-	+	-	-	+
Ig lambda	SN 5' ACCTARACGGTSASCTKGGTCCC 3' AS 5' TCYTMGTGWGCTGACTCAGSMCC 3'	+	+	-	-	+
Prothrombin	SN 5' GGGCTGGATGAGGACTCAG 3' AS 5' AAGGCAACAGGCTTCTTCAG 3'	-	-	-	-	+

Ret = retina; R/Ch = RPE/choroid; Gen = amplification of genomic DNA by the primer pair; * = higher molecular weight genomic band detected with primer pair.

Table C: Compositional comparison of extracellular disease deposits

	VN	Amyl-oid P	Apo E	Comple-ment	Elastin Involved	PGs	Lipids	Calcium
Drusen	+	+	+	+	?	-	+	+
Elasto-sis	+	+	?	+	+	?	- *	? †
Amyl-oids	+	+	+	+	+	+	-	+
Dense Depo-sits	+	+	?	+	?	+	+	?
Athero plaques	+	+	+	+(C5b-9)	+		+	+

*Sudanophilia has been described with actinic elastosis.

†Calcification of elastic fibers occurs in pseudoxanthoma elasticum.

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Example 8: Morphological Characterization of "Choroidal Fibrosis":

Human donor eyes -- with and without clinically-documented AMD and/or arterial wall disruptive disorders (AAA, TAA, aortic stenosis, and atherosclerosis) and with distinct drusen morphologies -- were employed for simultaneous transmission electron microscopical and immunohistochemical observation. Eyes used in this study were selected from a repository of over 2,000 pairs of human donor eyes (between 0 and 102 years of age) obtained from MidAmerica Transplant Services (St. Louis, MO), the Iowa Lions Eye Bank (Iowa City, IA), the Heartland Eye Bank (Columbia, MO) and the Virginia Eye Bank (Norfolk, VA) and were processed within four hours of death. The gross pathologic features of all eyes, as well as the corresponding ophthalmic histories, fundus photographs and angiograms, when available, were read by a retina surgeon. Approximately 18% of the donors had some form of clinically diagnosed AMD; these included eyes with macular pigment changes, macular drusen, geographic atrophy, choroidal neovascularization, and/or disciform scars. Eyes with and without clinically documented AMD, were employed in this study.

The RPE-choroid-sclera complex from 151 of these donors were processed for transmission electron microscopical examination. Tissues were fixed in one-half strength Karnovsky's fixative within four hours of death for a minimum of 24 hours, and transferred to 100mM sodium cacodylate buffer, pH 7.4, prior to dehydration, embedding, sectioning, and photomicrography.

Tissues from the same eyes processed for electron microscopy were processed for light histological (Elastachrome stain; H&E) and immunohistochemical studies. Anti-vitronectin antibody was obtained from Telios (San Diego, CA); collagens I, III, V, and VI from Chemicon and Southern Biotech; elastin from Elastin Products; fibrillin-1 from Chemicon; and fibulins 3 and 4 from Rupert Timpl. Selected specimens of human donor RPE-choroid were fixed by immersion in 4% (para)formaldehyde in 0.1M sodium cacodylate buffer and processed for laser scanning confocal microscopy. Images were captured and displayed using a BioRad 1024 laser scanning confocal microscope equipped with a Nikon inverted microscope.

The choroidal stromas of 30 of these individuals are filled with newly synthesized collagen, elastin, elastin-associated microfilaments, and other distinct structural proteins and fibrils as viewed by electron microscopy. Based on preliminary immunohistochemical analyses, the collagen associated with this condition appears to be largely type III and VI and

typically exhibits a "spiraled", or "frayed" morphology that is often associated with specific hereditary and acquired diseases. This previously undescribed phenomenon, referred to as "choroidal fibrosis", shares many pathological features that are common in arterial wall disruptive disorders.

TEM Choroidal Photolysis Database Table 1

Donor #	age	sex	Cause of death	Past medical history	part of the Ey	Choroidal fibrils	Need add. EM/Re	AMD, AAA
84-97	6 h	wM	chromosomal anom.		AM	1-		
					AI-1	1 c/e	EM	
					AI-2	1 c/e		
124-98	21 y	wM	Suicid, GSW-heal	Smoker	BM	1 c	EM	
					BI-2	1 c		
140-98	25 y	cF	Blood clot,	Kidney stone,	AM	1 c/e		
			pulmonary emboli	No smoker	AI-2	1 c		
163-98	25 y	wM	Suicid, GSW	No smoker	AI-2	2 c/e		
183-97	32 y	wF	Brain tumor	mental. retard.	AI-1	?	EM	
					BI-1	?	EM	
125-97	49 y	wM	Cardiomyopathy	CHF, glomeruloneph	AM	?	EM	
					AI-1	1 c		
64-98	44 y	wM	Head trauma, mol	No smoker, No eye	BM	1 c	EM	
			vehicle acc.		AM	?	EM	
152-98	48 y	wM	Mal. melanoma w	No smoker	BM	2 c/e		
			met.		BI-2	2 c/e		
93-98	55 y	wM	MI	CAD, CAAG-89, EIC	BM	?	EM	
				Tabac/cannab smok	BI-2	1	EM	
112-98	55 y	wM	MI, heart failure	renal insuff.(dialys)	BM	1		
				Diab w diab.retinopa	BI-2	2-3 c/e		
				Smoker				
147-98	52 y	wM	MI	Cardiomyopathy	AM	0	EM	
				Smoker	AI-2	2	2 EM	
165-98	57 y	wM	AVM	NIDDM, Hypothy.	AT-3	1 c/e		
					AI-2	2 c/e		
					BI-3	1 c/e		
					BI-2	2 c/e		
204-98	58 y	wM	Pulmonary HTN	Lung ca. IDDM, PV	AT-3	1 c	EM	
				PE, COPD, PVT	BT-3	1 c/e	EM	
				Smoker	AI-1	3 c/e		
#5-98	63 y	cF	Uterine ca w met.	HTN, AO valve mal	AI-2	1 e		
				function	BI-1	2 c/e	EM	
					BI-2	1 c	EM	
94-98	65 y	wF	Renal failure	ASHD, PVD, CVA, A	BM	1 c/e		AMD
				Former smoker	BI-2	1 c/e		
39-98	67 y	cM	MI	CAD, PVD, Diab, str	AM	1 e	EM	
				Smoker	AI-2	2+ c/e		
56-98	64 y	wM	Intracerebral bleed	EIOH, HTN	BM	?	EM	
			sepsis	Former smoker	BI-2	2 c/e		
71-98	68 y	wM	Multiple myeloma	COPD, CHF, renal	BT-3	2 c/e		
				failure, Smoker				
73-98	63 y	wM	Intraventricular	HTN, Smoker	AT-3	2 c/e	EM	
			bleed					
42-98	72 y	wM	MI	Cardiomyopathy, HT	AM	1 c/e	EM	AMD/NVM
				Diab., AMD	AI-2	1 c	EM	
				No smoker				
59-98	70 y	wM	aspiration pneum	cardiac dysrhythm.,	NAM	1 c	EM	AMD

61-98	76 y	wM	MI	atherioscl. Diab, AMD pneumonia, atherosclerosis prost.ca., AMD	BI-1 BI-2	2 c/e 2 c/e	EM EM	AMD
63-98	76 y	wM	gangrenous bowel	No smoker	BM BI-1 BI-3	? ? ?	EM EM EM	AMD
90-98	77 y	wM	MI	COD, aortic stenosis mitral valve prolapse	BT-3 AI-2	3 c/e 3 c/e	EM	AMD Aortic stenosis
186-98	78 y	wM	MI	HTN, AMD, No smoker MI-90, CAD, CABG	BT-3 BI-2	2 c/e 3 c/e	EM	AMD, AAA
194-98	78 y	wM	COPD	vessel surg., AMD, AAA AMD, AAA	BI-2	2 c/e 3 c/e	EM EM	AMD, AAA
56-95	70 y	wM	not given	HTN, AAA rep., prost.ca	BI-2 AI-2	? ?	EM EM	AAA
172-97	78 y	wM	MI	AAA repair	AI-2	? c, 3 e	EM	AAA
52-98	77 y	wM	renal failure	IDDM, Fam. hx AMD	BM	?	EM	
57-98	75 y	wM	cardiac event	COPD, MI x 2, HTN Smoker	BM AT-3	2+ c/e 3 c/e	EM EM	
76-98	73 y	wM	ICB	Aortic by-pass Former smoker	BT-3 BI-2	3 c/e 2 c	EM EM	
159-98	71 y	wM	Pontine bleed	Aortic valve replacement HTN, AMD, AAA	AI-2	3 c/e 1 ?	EM EM	
20-98	76 y	wF	Resp. failure Pneumonia	ASVD, DJD heart arrhythm. lung	AI-2 BI-2	2 c/e 2 c/e	EM	
47-98	78 y	wM	Pneumonia, active	IDDM, MI, prost. ca				
48-98	76 y	wM	TBC, lung ca					
207-98	74 y	wM	AAA	CAD, rec. pneumonia prost. ca Former smoker	BI-2	2 c/e		
238-98	76 y	wF	MI, spinal infarct.	MI, RNF. Smoker	AT-3 AI-2	3 c/e 3 c/e	EM	
34-97	83 y	wF	CHF	spinal inf. Smoker	BI-2	3 c/e		
174-97	84 y	wF	Rupt. AAA	CHF, COPD AMD, Glaucoma, psAM	AI-2 BT-3	3 c/e 2 c/e	EM EM	AMD, AAA Glaucoma
				vasc.disease, CAD	BI-2	?	EM	
					BI-3	?	EM	
					AI-2	3 c/e	EM	
					AI-3	?	EM	
189-97	81 y	wF	CHF, stroke	CABG x2, MI, CHF AMD	AM	2 c/e	EM	AMD
					BI-1	3 c/e	EM	
					BI-2	3 c/e	EM	

TEM Choroidal Fibrosis Database Table 1

55-98	83 y	wM	Lung ca, sepsis	Diab., COPD, Smok	BT-2	3 c/e	EM	AMD
85-98	86 y	wM	Congestive heart failure	Stroke, HTN	AM	2 c/e	EM	AMD
					AI-1	2 c/e	EM	
60-97	87 y	wF	Ruptured TAA	pre-systemic CA	AI-1	3 c/e		AAA
					AI-2	3 c/e	R	
					BI-1	3 c/e	R	
					BI-2	3 c/e		
117-97	81 y	wM	GPA	AAA, Dementia, COAM		3 c/e	EM	AAA
#9-98	80 y	wF	Sepsis	HTN, pneumonia	BM	2 c/e	EM	
					BI-2	2 c/e	EM	
14-98	82 y	wF	MI	not given	BI-2	3 c/e		
21-98	87 y	wM	Intracerebral bleed	No smoker	BI-2	3 c/e		
29-98	81 y	wM	Multisystem organ failure	No smoker	BI-2	?	EM	
38-98	82 y	wM	MI	Glaucoma, Smoker	AI-2	?	EM	Glaucoma
239-98	83 y	wF	CHF	HTN, breast ca, AA	BM	?	EM	AAA, TAA
				TAA, Smoker	BI-2	3 c/e	EM	
278-98	80 y	wF	Dissect. AA	CVA, MI, Smoker	BI-2	3 c/e	EM	TAA
100-97	92 y	wM	MI	Not given, AMD	BT-3	2 c/e	EM	AMD
					AI	2 c/e	EM	
46-98	93 y	wF	Septic shock	CVA, CHF, IDDM, breast ca, AMD	BI-2	?	EM	AMD
51-98	93 y	wF	Resp. failure	HTN, HOH, CH7	AM	3 c/e		
			pneumonia	No smoker	BM	3 c/e		
58-98	94 y	wF	Colon ca	HTN, AMD, POAG	AM	3 c/e	EM	AMD, POAG
				No smoker	BI-2	2 c/e	EM	
68-98	91 y	wF	CVA/CHF	Aortic stenosis+valv	BM	2 c/e	EM	AMD, Glaucoma
				heart disease, HTN, AMD, Glaucoma				
100-98	90 y	wF	Intracranial bleed	No smoker	AT-3	?	EM	
107-97	101 y	wF	Pneumonia	Not given	BT-3	2 c/e	EM	
					AT-a	2+ c/e	EM	
					BI-1	?	EM	
					BI-2	3 c/e	EM	
					AI-1	3 c/e	EM	
161-98	76 y	wM	Sepsis, CHF	HTN, PVD, CHF, failure, AMD-GA	ret BI-2	2+ c/e		AMD-GA
				Former smoker				
27-98	77 y	wM	Resp. failure, pneumonia	Pulm. fibrosis, HTN	BM	3 c/e		Pulm fibrosis
				TIA, CAD, Aortic by-pass, Former smoker				
					BI-2	3 c/e		
152-97	57 y	wM	Pulm fibrosis	Pneumonia, NIDDM	BM	2 c/e		AMD, pulm fibrosis
				pulm hypertension				
				AMD				
256-98	77 y	wM	Post CABG/CVA	HTN, COPD, pulm embolus x 2, prost.ca	BI-2	3 c/e		AAA, dissect
				Aortic dissect.				
				Former smoker				
					BM	?	EM	

TEM Choroidal Fibrosis Database Table 1

27-98	77 wM	Resp. failure sec. pulmonary fibrosis	Aortic by-pass, HTN AI-2	2? c/3 e	2 e		
38-97	94 wF	multisystem failure	TIA, CAD, Smoker AMD, HTN, congest AI-2	3 c/e	3 c/2 e		AMD
24-98	81 wM	MI/CHF	No smoker heart failure	3 c/2 e	2 c/e		
91-98	81 wM	pneumonia, sepsis	lobectomy, PVD, CcBT3	?	?		EM
94-98	65 wF	renal failure	HTN, No smoker AMD, ASHD, PUD, BM	?	?		EM
			degen. arthritis	2 c/e	2 c/e		EM
			Former smoker				
114-98	76 wF	CHF	ischemic cardiomyo B1-3	?	?		EM
			CAD, smp MI, HTN, CHF				
			renal insuff				
			No smoker				
159-98	71 wM	pontine bleed	AAA, AMD?, aortic AI-2	?			EM
			valve replacement,				
			HTN, CABG				
			Former smoker				
180-99	82 cM	pneumonia	multisystem organ B1-2	?			EM
			failure, cardiac history				
			CHF, acute renal failure				
			atherosclerosis of				
			descend. thoracic aorta				
			Former smoker				
31-99	69 wF	failed AAA	diffuse atheroscler BM	?			EM
			disease + throughout				
			aorta, HTN, coronary-				
			artery by-pass-90.				
			fam hx for vasc. disease				
			Smoker				

TEM Choroid Fibrosis Database Table 2

Donor #	age	sex	Cause of death	Past medical history	part of the Eye	Choroidal fibrils little/medium/lots in chor.	in sclera	Need add. EM/Ret	AMD,AAA
1-92	71	wM	cerebellar hema-		BM	1			
			toma		BTb	2			
10-92	53	M	MI		BM	1			
					ATb	1			
20-92	63	cM	acute renal failure		AM	2			
					ATb	2			
28-92	61	cF	resp. arrest	lung ca, high dosis of steroids -> leukocytosis	AM	1			
					BTb	2			
44-92	79	wM	liver ca		AM	1			
					ATb	1			
45-92	48	bM	cardiac-pulm		AM	2			
			arrest, r/o MT		ATb	1			
			VS PE						
49-92	18	bM	suicid, GSW to		AM	1			
			the head						
58-92	17	wM	head injury due		AM	1			
			to MVA						
81-92	50	bF	not given	CPA, schizophrenia	BM	?			
89-92	38	bF	subarachnoidal		AM	1			
			hemorrhage						
91-92	54	wM	subarachnoidal		BM	2			
			hemorrhage						
93-92	62	wF	cardiac arrest/ congest. heart		AM	1			
			failure						
95-92	72	wF	cerebral bleed		BTb	2			
96-92	71	wM	met. ca with cardiovasc. occlus		AM	2			
			and CHF						
97-92	59	wF	spinal ca		AM	2			
98-92	22	wM	head injury		AM	1			
					ATb	1			
99-92	69	wF	resp. failure	lung ca	BM	1			
100-92	36	wF	lung ca w. met.	Horners syndrome, HT	AM	2			
101-92	58	wF	cancer		BM	2			
102-92	65	wM	cardiac arrest		AM	1			
104-92	53	wF	r/o invasive candiasis		AM	2			
109-92	22	wM	heat stroke		BM	1			
110-92	30	bM	GSW to head	prob. TB or histoplasm	AM	2			
					ATb	1			
111-92	62	wM	lung ca		BM	2			
113-92	42	wF	brain tumor		AM	1			
114-92	58	wM	ischemic cardio- myopathy		AM	2			
115-92	13	wM	head injury		AM	1			
116-92	76	wF	MI, cardiac		AM	1			

117-92	69 bF	arrest	prob. MI due to renal disease, hemodialysis	BM	?		
		renal metaboloid	MI, atheroscl. heart				
		acidosis	disease, degen. heart dis.				
119-92	61 wM	CVA-stroke	CVA (right), left carotid	BM	1		
			disease, HTN, diab type II				
120-92	56 wM	MI	HTN, coronary artery	AM	2		
			disease, alcoholic liver				
			disease				pulm fibrosis
121-92	57 wM	O-26, poles-TB	resp. failure, atypical	BM	3+		
			CHF, ASHD, COPD, MBTb		2+		
			pulmonary fibrosis				
123-92	47 wF	multisystem		AM	1		
		organ failure					
124-92	70 wF	MI, cardiac-pulm		BM	2		
		arrest					
125-92	78 wM	resp failure		AM	2		
126-92	79 wM	MI, cardiac	bradycardia, pacemaker	AM	?		
		arrest		ATb	3		
				ATC	2		
130-92	61 wM	CPA sec to pulm		AM	2		
		edema					
133-92	60 wF	pacemaker	sarcoidosis, astma,	BM	2		
		failure	hyperthy.	BTb	3		
134-92	69 wF	anoxia	CVA, HTN	ATb	1		
135-92	51 wM	rectal ca w. pul	Cushing syndrome, AM		2		
		met.	steroid myopathy, diab.				
138-92	42 wM	cardiac-pulm		BM	?		
		arrest					
139-92	27 BM	GSW to heart		BM	2		
				BTb	2		
140-92	34 wF	not given	astma	AM	?		
141-92	50 wM	massive head	diab	AM	2		
		injury					
142-92	15 wF	head injury sec	splenectomy	AM	2		
		to MVA					
143-92	82 wF	resp failure	CHF, COPD, pneumoni	BM	2+		
				BTb	2		
149-92	75 wM	resp failure, MI	recent MI, atheroscl.	BM	1		
			heart disease, mild CH	BTb	2		
			chronic A-fib	BTd	2		
150-92	91 wM	stroke	emphysema, chron rel	BM	2		
			insuff, atherosclerotic	BTb	2		
			heart disease				
151-92	80 wM	CHF		BM	1+		
152-92	81 wF	CHF		AM	2		
153-92	18 wF	cerebral edema		AM	1+		
154-92	61 wF	gallbladder ca		BM	2		
		w met		BTb	2		
155-92	75 wF	COPD	cerebellar degen, pulm	AM	scar tissue		

156-92	36 wM	aneurysm + major head trauma/MVA	embolism, possible ANATb	AM	2	2
		subdural hematom				
158-92	68 wF	breast ca w me HTN		AM	1+	
162-92	45 wM	head injury		AM		2
163-92	52 wF	subarachn	HTN, migraine, CHF, ATa	ATa	?	
		hemorrhage	cardiomyopathy			
			breast ca w met			
166-92	96 wF	CHF		ATb		2
168-92	60 wM	full arrest, c/p	lung ca w met	AM		2
169-92	59 wF	CHI-intracere-	HTN	AM		2
		bral hemorrhage		ATb		1
171-92	38 wM	PE		AM	?	
				ATc		1
175-92	55 bM	colon ca w met		BM		2
176-92	66 wF	endometrial		AM		2
		ca w met				
179-92	37 wF	PE	livercirrhosis sec to EIO	AM		2
			portal HTN			
180-92	62 bM	resp arrest		BM	?	
		larynx ca				
181-92	85 wF	?	TIA	BM		2
182-92	47 wM	brain tumor		AM	1+	
				ATb		2
183-92	72 wM	MI	GI bleed	BM		1
185-92	96 wM	pneumonia sec to CHF		BTa		3
				BTb		3
				BTC		2
				BTd		2
				BTe		2
				BI		2
186-92	66 wF	CVA		AM	1+	
				ATb		1
187-92	79 wM	anoxia sec to carotid artery		AM		2
		occlusion		ATb	1+	
188-92	14 wM	cardiomyopathy		AM	1+	
		sec to muscular				
		dystrophy				
189-92	64 wM	prob. dysrhythm	CVD, diab	AM	1+	
192-92	86 wF	cardiac-pulm		BM		2
		arrest				
193-92	68 bF	sepsis		AM		2
				ATb		2
194-92	78 wM	cardiac-pulm	cardiomyopathy, CHF	AM		1
		arrest	alcoholism	ATb		1
195-92	75 wM	cardiac arrest	atherosclerosis, CV-	AM		1

OCELO® TEM Choroid Fibrosis Database Table 2

			sec to atheros disease					
			CV disease					
198-92	82 wM		cardiac-pulm	BM		2		
			arrest					
199-92	60 wM		cancer	AM		1		
200-92	53 wM		multisystem	HTN, sclerotic cardio- BM		1		
			failure	myopathy w CHF				

Expression *Control*

Example 9: Gene Expression of Fibrotic Molecules in Choroids of Control, AMD, and Arterial Wall Disruptive Disorders:

Total RNA was isolated from adult human liver and the RPE/choroid complexes from five control human donors (aged 18 to 58 years), one AMD/AAA donor, one AMD/aortic stenosis donor, and one AMD donor with a family history of AMD. The resulting pellets were stored at -80°C. The quality/integrity of RNA obtained was assessed on both agarose gels and Northern blots. cDNA was synthesized with reverse transcriptase using oligo(dT)16 as a primer. The enzyme was omitted from control reactions.

RT-PCR analyses of RPE-choroid complexes derived from this series of control (non-diseased) and affected (AMD/AAA, AMD, AMD/aortic stenosis) donors reveal distinct patterns of up- and down-regulated gene expression between the two groups (see Table D below). These include "upregulation" of b1 integrin, elastin, collagen VIa2, collagen a3, PI-1 (antitrypsin), PI-2, human metalloelastase (and perhaps fibrillin-2) and "downregulation" of BigH3. No detectable differences in expression levels of collagen IIIa1, collagen Ia2, collagen 6a1, fibulins-1, 2, 3, 4, and 5, HLA-DR, Ig kappa, laminin receptor, or laminin C2 were observed. Because of the limitations of RT-PCR, additional real time quantitative RT-PCR studies are being conducted to assess the precise levels of these genes in the two groups.

Example 10: Autoantibodies Associated with AMD/Arterial Wall Disruptive Diseases:

In order to address the role of autoantibodies in AMD and arterial wall disruptive disorder pathogenesis, including drusen biogenesis, we performed a series of preliminary experiments using enriched drusen preparations in order to identify anti-drusen/Bruch's membrane/ RPE autoantibodies that might be present in the sera of donors with AMD and AAA.

Protein extracts from an enriched drusen preparation (DR+) obtained by debridement of Bruch's membrane with a #69 Beaver blade and from a control (DR-) preparation were prepared using PBS with proteinase inhibitor cocktail and mild detergent. Proteins were separated by molecular weight using 10-20% gradient mini SDS gels (Amresco) and transferred to PVDF membranes for Western blot analysis. PVDF strips with human retinal proteins from 50 normal human retinas were also used for detection of any anti-retinal autoantibodies in the donor sera.

Sera from the same eight donors described above were screened. Serum from one AMD donor (#90-98) positively labeled a band in the RPE (both DR+ and DR-) and RPE/choroid preparations of approximately 35kDa. A second band of approximately 60kDa was labeled

Example 9

Table D: Gene Expression in AMD and Arterial Wall Disruptive Disorders

Molecule	Expression in Fibrosis vs Controls
BIG H3	Decreased
b1-integrin	Increased
Collagen 3 a1	Unchanged
Collagen 1a1	Unchanged
Collagen 1a2	Unchanged
Collagen 6 a1	Unchanged
Collagen 6 a2	Increased
Collagen 6 a3	Increased
Elastin	Increased
Emilin	
Fibulin-1	Unchanged
Fibulin-2	Unchanged
Fibulin-3	Unchanged
Fibulin-4	Unchanged
Fibulin-5	Unchanged
FBN-1	?
FBN-2	?
Ficolin	?
HLA-DR b	Unchanged
HME	Increased
IgK	Unchanged
Laminin Receptor	Unchanged
Lam C1	?
Lam C2	Unchanged
LamC3	?
LO2	Unchanged
LO4	Unchanged
LTBP-1	?
LTBP-3	?
LTBP-4	Decreased
MFAP-1	Decreased
MFAP-2	Decreased
MFAP-3	Unchanged
MFAP-4	Unchanged
MMP-2	Unchanged
MMP-7	?
MMP-9	?
MMP-12	Unchanged
PI-1	Decreased
PI-2	Decreased
PI-3	?
PLOD2	Unchanged

PM5	Unchanged
RPE-65	Unchanged
TIMP-1	Unchanged
TIMP-2	Unchanged
TIMP-3	Unchanged
Vitronectin	Increased?

protein (#189-
weakly only in the DR+ protein extract. Sera from an AAA donor (#189-97) reacted with a protein(s) of approximately 53kDa. This band labeled in all three protein extracts. There was one band of approximately 64kDa that this serum sample labeled only in the DR+ sample.

The presence of serum anti-drusen/RPE autoantibodies in donors with AMD/AAA suggests a possible role for shared immune-mediated processes in these disorders.

Example 11: Differential Gene Expression Analyses in AMD and Arterial Wall Disruptive Disorders:

Differential gene expression of RPE/choroid complexes derived from four paired donors of selected AMD and AAA phenotypes and age-matched controls has been analyzed using gene array analysis. The arrays utilized in this study contained 18,380 non-redundant cDNAs derived from the I.M.A.G.E. consortium. Each cDNA clone was robotically spotted, in duplicate, onto a nylon membrane in a precise pattern, allowing easy identification. These analyses are typically performed using first strand cDNA which has been radiolabeled during reverse transcription of the probe mRNA. However, due to the small amounts of mRNA that can be isolated from the RPE layer of individual human donor eyes, we have modified this standard protocol. The cDNAs were radiolabeled with 33-P in a random-primed reaction, purified, and hybridized to the gene arrays. The arrays were phosphoimaged, the signals were normalized, and the data analyzed using the Genome Discovery Software package (Genome Systems).

Analysis of the data reveals distinct patterns of clones that are significantly up- and/or down-regulated in the RPE/choroid of individuals with specific AMD and AMD/AAA phenotypes as compared to controls. At this point, these differentially-expressed mRNAs can be grouped into three distinct "pathways": extracellular matrix-, membrane transport-, and gene regulation-associated pathways. In addition, a significant number of uncharacterized expressed sequence tags (ESTs) are differentially expressed in the RPE-choroid of donors with specific AMD and AAA phenotypes as compared to the RPE from donors without the disease.

Field	Pos	Pat	File A Int	File B Int	Score	Ratio	Int. Diff	ClonID	Cluster	GB Acc	Unigene	FL
1	k07	2	1176.28	5834.56	23105.99	4.96	4658.29	129473	Cluster	R11336	Hs. 137763	
1	l16	8	56.97	1797.19	17400.51	9.999	1740.22	382701	Cluster	AA069532	Hs. 5729	
1	b20	4	1822.77	6556.43	17026.8	3.597	4733.66	52489	Cluster	H24274	Hs. 111	HT2447
1	j21	1	212.69	2005.38	16902.68	9.429	1792.69	24032	Cluster	T78285	Hs. 90863	
6	j16	4	163.58	1598.01	14013.13	9.769	1434.43	209303	Cluster	H63368	Hs. 114004	
4	o20	5	157.71	1546.53	13619.05	9.806	1388.83	245873	Cluster	N72922	Hs. 22341	
3	e23	7	302.16	2050.34	11862.4	6.786	1748.18	60874	Cluster	T39572	Hs. 760	HT125
4	k14	3	103.78	1272.09	11681.88	9.999	1168.3	154571	Cluster	R54764	Hs. 26204	
6	k09	4	175.41	1488.99	11150.73	8.489	1313.58	204705	Cluster	H57226	Hs. 75641	HT1045
2	a21	5	854.08	3399.24	10129.68	3.98	2545.15	230370	Cluster	H75530	Hs. 16	HT1675
2	n01	7	502.82	2403.48	9085.11	4.78	1900.66	325821	Cluster	AA037110	Hs. 75970	
2	c10	5	1363.71	4238.44	8934.73	3.108	2874.73	223293	Cluster	H86270	Hs. 75219	HT1234
4	a17	7	1222	3963.27	8890.6	3.243	2741.26	346854	Cluster	W78125	Hs. 47584	
6	j12	4	667.51	2740.32	8509.41	4.105	2072.8	209281	Cluster	H65578	Hs. 114188	
1	k05	5	384.91	1928.92	7737.58	5.011	1544.01	211857	Cluster	H68430	Hs. 109450	
1	j03	6	691.74	2668.3	7624.31	3.857	1976.56	271256	Cluster	N44562	Hs. 44613	
5	i23	5	82.28	812.89	7217.65	9.879	730.61	255777	Cluster	N27758	Hs. 43993	
6	j08	4	673.92	2548.31	7087.75	3.781	1874.4	209276	Cluster	H63352	Hs. 38194	
1	l18	2	791.1	2789.36	7045.66	3.526	1998.25	27689	Cluster	R13106	Hs. 139029	
5	m19	4	645.56	2436.57	6759.91	3.774	1791.01	198896	Cluster	H83192	Hs. 62402	
6	i21	5	466.27	2015.03	6693.1	4.322	1548.76	260214	Cluster	N45406	Hs. 141460	
2	e16	5	591.78	2252.83	6323.28	3.807	1661.04	223625	Cluster	H86968		
2	c01	6	435.12	1888.04	6304.44	4.339	1452.92	273917	Cluster	N46505		HT2245
1	l17	1	2724.39	5641.93	6041.94	2.071	2917.54	22140	Cluster	T64807	Hs. 100132	
1	i12	3	160.64	1061.74	5955.53	6.609	901.09	69940	Cluster	T48696	Hs. 110286	
1	i02	5	963.71	2920.39	5929.48	3.03	1956.68	213484	Cluster	H71668		
2	g11	5	1565.45	3881.45	5742.45	2.479	2316.01	222246	Cluster	H86008		
6	j06	2	1004.89	2937.73	5650.48	2.923	1932.83	135085	Cluster	R33918	Hs. 72824	
3	p20	2	312.73	1485.66	5572.18	4.751	1172.93	36189	Cluster	R21373	Hs. 76335	
5	n16	4	787.46	2520.84	5648.92	3.201	1733.38	203557	Cluster	H56112		
4	b05	1	883.66	2597.03	5035.47	2.939	1713.37	118792	Cluster	T92527	Hs. 111916	
1	d19	8	1077.33	2922.77	5006.66	2.713	1845.45	380535	Cluster	AA053898	Hs. 114818	
1	i06	3	502.37	1851.41	4971.72	3.685	1349.05	137710	Cluster	R37989		
6	f08	6	754.48	2326.29	4846.36	3.083	1571.81	306146	Cluster	W20101		
4	a15	7	1283.96	3206.94	4803.01	2.498	1922.98	344774	Cluster	W74705	Hs. 1550	HT3851
1	e24	1	378.8	1543.61	4746.59	4.075	1164.81	22897	Cluster	T75253	Hs. 12333	
6	n09	4	1369.32	3321.23	4734.26	2.425	1951.9	208059	Cluster	H62639	Hs. 103424	
6	j24	6	1311.86	3223.23	4696.21	2.457	1911.37	306759	Cluster	W23986	Hs. 31880	
6	i17	4	577.51	1955.77	4667.48	3.387	1378.25	204656	Cluster	H57192	Hs. 141602	
1	j11	8	182.5	1011.75	4597.17	5.544	829.25	380978	Cluster	AA057398		
6	j12	2	325.65	1394.27	4575.27	4.281	1068.62	135107	Cluster	R33933	Hs. 106200	
2	d22	4	1090.95	2826.91	4498.36	2.591	1735.97	176889	Cluster	H45241	Hs. 108124	
2	c01	5	492.25	1751	4477.6	3.557	1258.75	222032	Cluster	H85307	Hs. 78150	HT3629
1	j17	8	182.25	991.11	4398.7	5.438	808.86	380987	Cluster	AA057468		
6	k20	5	215.73	1044.01	4008.33	4.839	828.28	263914	Cluster	N28535	Hs. 75428	HT3218
1	j15	8	477.77	1632.59	3946.08	3.417	1154.81	380986	Cluster	AA057467	Hs. 47068	
1	c23	6	432.87	1530.32	3879.81	3.535	1097.45	267778	Cluster	N34196		

Gene Array Analysis Database 1

Field	Identity
1	Soares fetal liver spleen 1NFLS (ESTs)
1	Soares pineal gland N3HPG (ESTs)
1	Soares infant brain 1NIB/ similar to glia-activating precursor (fibroblast growth factor 9)
1	Soares infant brain 1NIB/ human death domain containing protein CRADD mRNA
6	Soares fetal liver spleen 1NFLS/ highly similar to heat shock cognate 71kd protein- human protein mRNA
4	Soares fetal liver spleen 1NFLS/ similar to carboxypeptidase M precursor (Homo sapien LIM protein mRNA- pinch protein)
3	Stratagene placenta #937225/ similar to transcription factor GATA-2 (GATA-binding protein 2)
4	Soares breast 2NbHBst (ESTs)
6	Soares fetal liver spleen 1NFLS/ similar to galactose-1-phosphate uridyl transferase
2	Soares fetal liver spleen 1NFLS (V-erb avian sarcoma virus CT10 oncogene homolog)
2	Soares senescent fibroblast NbHSF/ similar to contains Alu repetitive element (Homo sapien mRNA for KIAA0632 protien, partial cds)
2	Soares retina N2b5HR/ similar to tyrosinase-related protein 1 precursor (5,6-dihydroxyindole-2-carboxylic acid oxidase precursor)
4	Soares fetal heart NbHH19W (Homo sapien Shab-related delayed-rectifier K+ channel alpha subunit mRNA, complete cds)
6	Soares fetal liver spleen 1NFLS (ESTs)
1	Soares fetal liver spleen 1NFLS (human Rho-associ., coiled-coil containing protein kinase p16ROCK mRNA, complete cds)
1	Soares melanocyte 2NbHM (highly similar to Homo sapien ATP receptor)
5	Homo sapien cDNA clone 255777 similar to contains Alu repetitive element (ESTs)
6	Soares fetal liver spleen 1NFLS/ similar to contains MER 6 repetitive element (ESTs)
1	Soares infant brain 1NIB (ESTs)
5	Soares fetal liver spleen 1NFLS/ similar to serine/threonine-protein kinase pak (Homo sapien p21 activated kinase PAK 1B mRNA)
6	Soares placenta 8-9 weeks 2NbHP8to0W (ESTs)
2	Soares retina N2b5HR
2	Soares melanocyte 2NbHM
1	Soares infant brain 1NIB/ similar to myosin heavy chain, nonmuscle type B-human
1	Stratagene placenta #937225 (ESTs)
1	Soares fetal liver spleen 1NFLS (ESTs)
2	Soares retina N2b5HR
6	Soares placenta Nb2HP (Homo sapien mRNA for sigma 3B protein)
3	Soares infant brain 1NIB (human 54 kDa protein mRNA, complete cds- PTB-associ. splicing factor)
5	Soares fetal liver spleen 1NFLS
4	Stratagene lung #937210 (ESTs)
1	Soares retina N2b4HR (ESTs)
1	Soares placenta Nb2HP
6	Soares parathyroid tumor NbHPA/ similar to methionyl-IRNA formyltransferase
4	Soares fetal heart NbHH19W/ similar to proteasome component C13-human (proteasome component C13 precursor)
1	Soares infant brain 1NIB (ESTs)
6	Soares fetal liver spleen 1NFLS/ similar to heat shock cognate 71KD protein- human
6	Soares fetal lung NbHL19W (ESTs, weakly similar to CMP-N-Acetylneuraminase-Beta-1,4-Galactosyl alpha-2,3-sialyltransferase)
6	Soares fetal liver spleen 1NFLS/ similar to contains Alu repetitive element, contains MIR repetitive element (ESTs)
1	Soares retina N2b4HR/ similar to contains DBR repetitive element
6	Soares placenta Nb2HP/ similar to contains Alu repetitive element (ESTs)
2	Soares adult brain N2b5HB55Y (60S ribosomal protein L41)
2	Soares retina N2b5HR (human K-ras oncogene protein mRNA, complete cds- transforming protein P21/H-RAS-1)
1	Soares retina N2b4HR
6	Soares melanocyte 2NbHM/ similar to superoxide dismutase- human (superoxide dismutase-1-Cu/Zn)
1	Soares retina N2b4HR/ similar to contains Alu repetitive element (ESTs)
1	Soares melanocyte 2NbHM/ similar to contains Alu repetitive element

Database 1

5h08	7	1148.27	2754.46	3852.93	2.399	1606.19	562186	Cluster	AA211593	Hs. 82129	HT3659
1h24	8	787.53	2147.49	3708.42	2.727	1359.96	382457	Cluster	AA069746	Hs. 84244	HT383
6i15	2	373.91	1371.78	3660.87	3.669	997.87	130980	Cluster	R23027	Hs. 138216	
6h13	2	395.69	1415.11	3645.8	3.576	1019.42	133702	Cluster	R28577		
2i01	2	230.66	1035.87	3615.96	4.491	805.2	28229	Cluster	R13333	Hs. 21305	
6h22	6	535.45	1665.93	3517.31	3.111	1130.49	306412	Cluster	W20275		
6i10	2	1079.98	2551.97	3478.28	2.363	1471.99	132237	Cluster	R25219	Hs. 23817	
3i14	7	654.63	1843.77	3349.17	2.816	1189.14	85533	Cluster	T72189		HT1389
3i02	1	3273.06	5327.27	3343.46	1.628	2054.21	114073	Cluster	T79540	Hs. 111782	
2i13	2	599.82	1742.2	3318.07	2.905	1142.38	28466	Cluster	R13379	Hs. 64135	
1b24	3	136.08	741.53	3299.14	5.449	605.45	139990	Cluster	R64675	Hs. 24167	
5i23	6	331.56	1218.26	3258.05	3.674	886.7	297963	Cluster	N98325	Hs. 137909	
4i18	2	1254.85	2725.78	3195.13	2.172	1470.93	37482	Cluster	R33062		
1k23	4	188.47	875.74	3193.53	4.647	687.28	50141	Cluster	H17788	Hs. 31066	
4i23	2	371.59	1288.77	3181	3.468	917.18	37109	Cluster	R34443		
2i13	4	863.3	2132.38	3134.63	2.47	1269.07	174664	Cluster	H40649		
6i22	1	977.26	2299.56	3111.47	2.353	1322.3	128161	Cluster	R09793	Hs. 27931	
2i07	5	583.06	1667.72	3102.44	2.86	1084.66	230996	Cluster	R96161	Hs. 138512	
3i23	4	835.38	2074.03	3075.28	2.483	1238.66	179905	Cluster	H50920		
1i10	4	539.16	1583.6	3067.65	2.937	1044.43	52618	Cluster	H29394		
6i11	5	739.02	1916.38	3053.03	2.593	1177.36	264848	Cluster	N29101	Hs. 75503	HT3684
2i20	4	184.88	848.95	3049.52	4.592	664.08	172473	Cluster	H20257		
6i02	2	1234.95	2637.47	2995.38	2.136	1402.53	133002	Cluster	R24476		
1i05	1	752.32	1920.24	2981.04	2.552	1167.92	21917	Cluster	T66051		
2i12	3	419.6	1345.01	2966.42	3.205	925.42	142882	Cluster	R71543	Hs. 141964	
1j01	6	731.53	1882	2959.8	2.573	1150.47	271252	Cluster	N34571	Hs. 41663	
6i10	5	496.23	1483.88	2953.47	2.99	987.66	262754	Cluster	N28295	Hs. 141435	
2i01	1	117.94	651.36	2946.02	5.523	533.42	110759	Cluster	T83266	Hs. 100090	
4i20	7	94.4	574.28	2919.33	6.083	479.88	530260	Cluster	AA111987		
5i02	1	1426.28	2874.44	2918.56	2.015	1448.17	=====	Cluster	#NAME?		
2i05	1	365.5	1230.09	2909.82	3.366	864.59	110893	Cluster	T82879	Hs. 13756	
1j05	8	151.81	744.28	2904.96	4.903	592.48	380914	Cluster	AA057495	Hs. 76224	HT3350
1i14	6	465.37	1417.51	2900.22	3.046	952.14	270035	Cluster	N40606	Hs. 141444	
6i05	1	467.94	1417.75	2877.74	3.03	949.81	125636	Cluster	R07461		
5i02	6	1029.9	2307.86	2863.74	2.241	1277.96	295400	Cluster	W04464	Hs. 138522	
6i10	4	482.43	1435.72	2837.01	2.976	953.29	209204	Cluster	H62020		
6i16	6	336.18	1159.02	2836.78	3.448	822.84	302070	Cluster	W17034	Hs. 363	
2i11	5	1752.63	3263.61	2813.62	1.862	1510.98	222409	Cluster	H86161	Hs. 141367	
6i03	7	2336.16	3983.14	2808.07	1.705	1646.97	626746	Cluster	AA216447	Hs. 89608	HT115
1i03	2	422.22	1316.61	2789.02	3.118	894.39	129413	Cluster	R11257		
2i09	2	1458.79	2867.56	2769.26	1.966	1408.78	28657	Cluster	R14286		
1i14	3	387.9	1244.45	2747.85	3.208	856.54	137744	Cluster	R68503	Hs. 138231	
6i21	3	549.28	1532.33	2742.42	2.79	983.05	47817	Cluster	H11685		
1i03	4	364.21	1192.63	2712.67	3.275	828.42	49961	Cluster	H29383		
4i23	3	242.97	934.16	2657.46	3.845	691.19	153354	Cluster	R47887	Hs. 71388	
4i17	1	398.91	1246.35	2647.64	3.124	847.43	119302	Cluster	T98238		
1i19	5	561.86	1532.3	2646.57	2.727	970.44	211202	Cluster	H67987	Hs. 38654	HT889
1i06	5	448.71	1335.34	2638.51	2.976	886.62	220470	Cluster	H87319	Hs. 1432	
6i19	5	1624.7	3030.57	2622.38	1.865	1405.87	259279	Cluster	N41802		

5	Stratagene muscle #937209 (carbonic anhydrase III- human)	
1	Soares pineal gland N3HPG (Homo sapien potassium channel Kv2.1 mRNA, complete cds)	
6	Soares placenta Nb2HP (ESTs)	
6	Soares placenta Nb2HP	
2	Soares infant brain 1NIB/ similar to contains Alu repetitive element, contains TAR 1 repetitive element (ESTs)	
6	Soares fetal lung NbHL19W/ similar to mouse brain protein H5	
6	Soares placenta Nb2HP (ESTs)	
3	Stratagene liver #937224/ similar to liver carboxylesterase precursor- human	
3	Soares fetal liver spleen 1NFLS/ similar to contains Alu repetitive element, contains MER22 repetitive element (ESTs- highly similar to myc-assoc. zinc finger protein- human)	
2	Soares infant brain 1NIB (ESTs, weakly similar to Alu subfamily J- human)	
1	Soares placenta Nb2HP (Homo sapien mRNA for novel gene in Xq28 region- synaptobrevin-related protein)	
5	Soares fetal lung NbHL19W/ similar to tumor necrosis factor receptor 2 precursor- human, contains Alu repetitive element (ESTs)	
4	Soares infant brain 1NIB	
1	Soares infant brain 1NIB (ESTs)	
4	Soares infant brain 1NIB	
2	Soares adult brain N2b5HB55Y	
6	Soares fetal liver spleen 1NFLS (ESTs)	
2	Soares pineal gland N3HPG/ similar to contains Alu repetitive element (ESTs)	
3	Soares adult brain N2b4HB55Y	
1	Soares infant brain 1NIB	
6	Soares melanocyte 2NbHM (Homo sapien TFE3 gene, exons 1,2,3- and joined cds/ transcription factor E3- human)	
2	Soares adult brain N2b5HB55Y	
6	Soares placenta Nb2HP	
1	Soares infant brain 1NIB	
2	Soares placenta Nb2HP/ similar to contains Alu repetitive element (ESTs)	
1	Soares melanocyte 2NbHM/ similar to human carcinoma cell-derived Alu RNA transcript (rRNA), activator 1 40 KD subunit- human (ESTs)	
6	Soares melanocyte 2NbHM/ similar to contains Alu repetitive element (ESTs)	
2	Soares fetal liver spleen 1NFLS (human globin gene)	
4	Stratagene fibroblast #937212/ similar to 60S acidic ribosomal protein P1- human	
5		
2	Soares fetal liver spleen 1NFLS (ESTs)	
1	Soares retina N2b4HR (human extracellular protein [S1-5] mRNA, complete cds- fibulin-1, isoform V precursor- human)	
1	Soares melanocyte 2NbHM (ESTs)	
6	Soares fetal liver spleen 1NFLS/ similar to heterogeneous nuclear ribonucleoprotein A1- human	
5	Soares fetal liver spleen 1NFLS/ similar to contains Alu repetitive element (ESTs)	
6	Soares fetal liver spleen 1NFLS/ similar to contains Alu repetitive element	
6	Soares fetal lung NbHL19W (zinc finger protein 139- clone pHZ-37)	
2	Soares retina N2b5HR (ESTs)	
6	Stratagene HeLa cell s3 #937216/ similar to protein phosphatase PP2A, 65KD regulatory subunit, beta- human (protein phosphatase 2, regulatory subunit A [PR65], beta isoform)	
1	Soares fetal liver spleen 1NFLS	
2	Soares infant brain 1NIB	
1	Soares placenta Nb2HP/ similar to contains Alu repetitive element (ESTs)	
6	Soares infant brain 1NIB	
1	Soares infant brain 1NIB	
4	Soares breast 2NbHBs/ similar to bovin cathepsin (Homo sapien cathepsin Z precursor [CTsZ] mRNA, complete cds)	
4	*not found on GB	
1	Soares fetal liver spleen 1NFLS/ similar to contains Alu repetitive element, contains PTR5 repetitive element (ESTs, highly similar to ribosomal protein S6 kinase II alpha 2- Mus musculus)	
1	Soares retina N2b4HR/ similar to contains Alu repetitive element (protein kinase C substrate 80K-H)	
6	Soares placenta 8-9 weeks 2NbHP8to9W/ similar to human carcinoma cell-derived Alu RNA transcript, cytochrome P450 1A2- human	

Database 1

1	23	8	537.38	1484.57	2616.8	2.763	947.2	381024	Cluster	AA054639	Hs. 36658
2	h04	4	1134.32	2370.98	2584.88	2.09	1236.65	177300	Cluster	H40720	Hs. 31775
4	109	7	286.02	1013.81	2579.66	3.545	727.79	511972	Cluster	AA102358	
1	a12	4	778.27	1845.08	2529.15	2.371	1066.81	20075	Cluster	H17348	Hs. 117688

Database 1

1 Soares retina N2b4HR/ similar to contains Alu repetitive element (ESTs)	
2 Soares adult brain N2b5HB5Y/ similar to contains L1 repetitive element (ESTs)	
4 Stratagene colon #937204	
1 Soares infant brain 1NIB/ similar to contains Alu repetitive element (ESTs, highly similar to Alu subfamily SB2- human)	

	File A Intensity	File B Intensity	Score	Ratio	Int Diff	ClonID	Genbank Acc#	FL	Protein Name
3 a19 7	9184.94	1506.99	46796.341	6.095	7677.96	73163	T56622	HT1291	TRANSTHYRETIN PRECURSOR
3 i16 7	6765.23	858.77	46529.972	7.878	5906.46	77938	T53808	HT4362	BIOTINIDASE
3 h17 8	4427.8	457.73	38404.236	9.673	3970.07	429711	AA011711	NA	TRANSTHYRETIN PRECURSOR
4 i23 4	13634	4261.84	29982.467	3.199	9372.17	195352	R89536	NA	TRANSTHYRETIN PRECURSOR
3 a17 7	8575.48	1960.49	28934.93	4.374	6614.99	67221	T52674	HT1501	VASCULAR ENDOTHELIAL GROWTH FACTOR RECEPTOR 1
3 a07 7	3329.61	360.95	27384.499	9.225	2968.66	60267	T40473	HT3094	HYPOTHETICAL PROTEIN 458 -
3 a20 7	2863.76	159.94	27035.506	9.999	2703.82	78438	T61381	HT4199	None
3 g14 3	1366.74	113.46	12531.495	9.999	1253.27	148991	R82287	NA	None
3 h24 5	2251.24	397.39	10502.04	5.665	1853.85	241622	H89823	NA	None
2 h15 3	1926.8	315.85	9827.459	6.1	1610.95	144221	R76995	HT3952	HEMOGLOBIN BETA CHAIN
1 e09 5	2850.47	670.44	9268.68	4.252	2180.03	211024	H65775	NA	None
3 k24 7	1125.37	135.09	8249.176	8.33	990.27	321075	W56898	NA	None
6 i18 8	1436.78	239.81	7171.337	5.991	1196.97	503812	AA131720	NA	APOLIPOPROTEIN D PRECURSOR
3 o19 3	1797.96	387.38	6546.89	4.641	1410.58	148425	H12367	HT1428	HEMOGLOBIN BETA CHAIN
2 p14 4	694.63	68.66	6259.164	9.999	625.98	178599	H49130	NA	None
3 d16 1	1219.74	211.03	5830.262	5.78	1008.71	114926	T86234	NA	None
5 e12 8	1551.17	327.42	5797.674	4.738	1223.75	489404	AA045613	NA	DHII_HUMAN P28845 CORTICOSTEROID 11-BETA-DEHYDROGENASE
3 d12 1	605.36	26.64	5786.524	9.999	578.71	114906	T86313	NA	AMINE OXIDASE
5 h22 7	893.55	127.18	5384.899	7.026	766.38	562243	AA211746	HT364	TROPONIN I, SLOW SKELETAL MUSCLE
1 h24 8	656.07	91.17	4065.086	7.196	564.9	382457	AA069746	HT383	None
6 a05 4	1665.65	491.39	3980.278	3.39	1174.26	203939	H56754	NA	None
1 g03 3	1546.44	432.72	3980.199	3.574	1113.72	136255	R33768	HT3651	HEMOGLOBIN BETA CHAIN
3 k15 3	1228.63	291.89	3942.82	4.209	936.73	147862	R81846	NA	FERRITIN LIGHT CHAIN
3 c07 1	455.31	49.42	3739.587	9.213	405.89	112471	T85895	NA	PROLIFERATION-ASSOCIATED PROTEIN PAG
3 b04 4	385.33	38.79	3442.657	9.934	346.54	166852	R88127	NA	None
3 g13 7	339.05	12.77	3262.47	9.999	326.28	66599	T67128	HT2167	ARYLAMINE N-ACETYLTRANSFERASE, MONOMORPHIC
1 g10 5	537.75	82.91	2950.05	6.486	454.84	213251	H70584	NA	None
3 h12 3	373.26	42.41	2912.46	8.803	330.86	151792	H03041	NA	None
3 i04 2	1628.21	597.02	2812.278	2.727	1031.19	33453	R19586	HT3628	MYELIN PROTEOLIPID PROTEIN
2 g15 4	4294.23	2602.04	2792.672	1.65	1692.19	166445	R88586	NA	None
6 b12 6	460.03	65.19	2785.896	7.056	394.84	23783	T77328	NA	None
5 i14 3	488.38	75.53	2669.285	6.466	412.84	44756	H06950	NA	CE00977 CHROMOSOME SEGREGATION PROTEIN
3 k10 5	2017.51	883.08	2591.77	2.285	1134.44	239053	H68587	NA	None
5 p11 4	1789.44	733.95	2573.41	2.438	1055.5	202302	H52973	NA	None
3 h06 5	507.47	84.77	2530.475	5.987	422.69	241545	H90605	NA	None
3 e01 5	1521.92	573.12	2519.566	2.656	948.8	233993	H66198	NA	None
5 d18 6	316.53	35.38	2515.081	8.946	281.15	298508	W04832	HT2858	HEMOGLOBIN ALPHA CHAIN
5 g16 3	468.65	75.17	2452.79	6.234	393.47	162918	H26802	NA	None
3 o20 1	926.68	266.35	2297.484	3.479	660.34	114073	T79540	NA	None
4 a07 2	3007.71	1711.9	2276.655	1.757	1295.81	36318	R21064	NA	None
3 b14 7	623.27	136.11	2230.936	4.579	487.17	328920	W45464	HT2857	HEMOGLOBIN ALPHA CHAIN
3 n06 5	357.25	50.7	2159.945	7.046	306.54	241976	H93930	NA	None
4 i23 1	1003.93	326.22	2085.655	3.077	677.71	120173	T95693	NA	None
5 k16 6	435.12	75.65	2067.536	5.752	359.47	296258	W03125	HT2833	HUMAN P04271 S-100 PROTEIN, BETA CHAIN
1 e10 8	397.18	64.08	2064.729	6.198	333.11	376888	AA046832	NA	None
3 e02 5	1285.12	499.24	2022.967	2.574	785.88	238413	H64769	NA	None
5 i03 4	1188.58	445.69	1981.149	2.667	742.89	201839	R99977	NA	INTERFERON-INDUCIBLE PROTEIN 9-27
3 a23 4	475.12	92.02	1978.202	5.164	383.1	178667	H49853	NA	A49098 N-HYDROXYARYLAMINE SULFOTRANSFERASE, HAST-I
6 n01 4	1682.83	784.43	1927.326	2.145	898.4	208017	H62616	NA	None
6 j20 8	707.27	192.25	1894.728	3.679	515.02	68791	T53417	NA	None

Field	Pos	Pat	File A	File B	Score	Ratio	Intensity	Clone ID	GBACC	Unigene	Identity
3	a077	29787.66	6274.97	111616.33	4.747	23512.7	60267	T40473	H111572	Human rearranged immunoglobulin lambda light chain mRNA	
2	a184	10238.67	1206.6	76642.77	8.486	9032.08	171864	H19169	None	Soares adult brain N2bSHB55Y: EST	
4	j065	12214.14	3268.24	33432.73	30737	8945.89	248425	N78171	108896	EST: highly similar to LAMBDA-CRYSTALLIN	
3	a197	33237.82	17809.8	28792.62	1.866	15427.97	73163	T56622	22024	Transhyretin (prealbumin, amyloidosis type I)	
3	h178	17668.78	7056.16	26574.23	3.504	10812.62	429711	AA011711	22024	Transhyretin (prealbumin, amyloidosis type I)	
2	a172	7979.7	2113.99	3452.6	3.016	6958.86	328377	W38364	107402	Gamma-aminobutyric acid A receptor, gamma 2	
3	h167	10411.45	3452.6	20984.75	3.016	6958.86	328377	W38364	107402	EST: pancreatic islet Homo sapiens cDNA clone	
3	a177	21456.68	10998.5	20402.52	1.951	10458.16	67221	T52674	235	Fms-related tyrosine kinase1: vascular endothelial growth factor	
4	i234	38879.97	28384.3	18413.45	1.474	12495.58	195352	R89536	22024	Transhyretin (prealbumin, amyloidosis type I)	
3	d107	3279.98	576.87	15369.43	5.886	2703.11	324801	W47197	34359	Cadherin 11	
4	a072	17808.39	10904.3	11275.39	1.633	6904.07	36318	R21084	29860	Soares senescent fibroblasts: EST	
4	n044	6204.53	2269.68	10756.54	2.734	3934.85	197281	R68998	124837	Soares infant brain: EST	
2	h153	8546.1	3807.22	10637.41	2.245	4738.88	144221	R76895	119499	Soares fetal liver spleen: EST	
4	i154	11278.61	5949.95	10100.93	1.896	5328.67	191938	H38996	20084	Hemoglobin, beta	
1	g033	6269.59	2554.69	9116.87	2.454	3714.89	136255	R33768	64797	Homo sapiens clone 23792 mRNA sequence	
5	h216	4063.07	1255.16	9089.46	3.237	2807.91	297148	W03961	None	Amyloid beta (A4) precursor-like protein 2	
2	g154	12005.53	6860.26	9004.28	1.75	5145.27	166445	R68586	None	Soares fetal liver spleen: EST	
1	n213	4323.6	1447.68	8569.07	2.987	2875.91	139543	R62231	78224	Soares adult brain: EST	
2	p144	9978.43	5421.15	8388.35	1.841	4557.28	178599	H49130	None	Ribonuclease, RNase A family 1 (pancreatic)	
3	i042	7244.96	3398.89	8198.13	2.132	3846.07	33453	R19586	1787	Soares adult brain: EST	
3	c155	6746.22	3297.81	7054.27	2.046	3448.4	233938	H66535	75573	Myelin proteolipid protein	
5	i167	709.48	30.37	6790.47	9.999	679.11	567007	AA152409	1034	Centromere protein E	
6	a054	6128.69	3005.33	3639.39	2.039	3123.36	203939	H56754	None	FK506-binding protein precursor	
3	c156	1042.88	148.25	6293.1	7.034	894.63	279519	N45619	None	Soares fetal liver spleen: EST	
5	i165	7495.31	4222.39	5809.88	1.775	3272.92	258873	N57334	None	Soares multiple sclerosis 2NBHMSF vector	
2	g153	1441.09	289.81	5724.69	4.972	1151.28	141700	R69655	None	Soares placenta 8 to 9 weeks: EST	
6	o242	2972.07	1017.3	5710.89	2.922	1954.76	133065	R26331	74470	Annexin II (lipocortin II)	
4	e114	5444.64	2683.03	5604.1	2.029	2761.61	191516	H38147	None	Soares fetal liver spleen: EST	
2	b157	1437.7	307.31	5238.49	4.659	1124.4	325121	W49691	1940	Crystallin, alpha B	
5	j038	656.88	77.33	4922.82	8.494	579.55	490976	AA136785	None	Soares pregnant uterus NbHPU Homo sapiens cDNA clone	
5	e063	4562.62	2217.18	4826.59	2.058	2345.45	162526	H28534	74802	Aquaporin-Chip	
3	e015	2697.04	973.47	4775.22	2.771	1723.57	323993	H66198	None	Soares fetal liver spleen: EST	
3	a218	1190.06	240.79	4691.46	4.942	949.26	418242	W90242	15106	EST: similar to hypothetical 17.1kD protein in Sah1-Med4 intergenic region	
4	k111	4785.04	2447.09	4571.64	1.955	2337.95	116427	T91421	124749	Soares fetal liver spleen: EST	
3	h245	5884.03	3425.95	4221.7	1.717	2458.07	241622	H98923	14912	Soares fetal liver spleen: EST	
4	a081	6827.39	4229.02	4194.84	1.614	2598.37	116797	T98571	106134	Homo sapiens mRNA for KIAA0286 gene; Soares fetal liver spleen: EST	
4	j232	1775.94	530.7	4167.06	3.346	1245.24	39167	R54351	12773	Soares fetal liver spleen: EST	
5	p118	1303.92	315.21	4089.97	4.137	988.71	491209	AA150295	17882	Homo sapiens mRNA for pristanoyl-CoA oxidase	
1	o017	1960.87	637.89	4066.81	3.074	1322.98	308548	W24939	1477	Soares pregnant uterus NbHPU Homo sapiens cDNA clone	
3	e025	1946.39	631.88	4049.14	3.08	1314.52	238413	H64769	None	Insulin-like growth factor binding protein 6	
2	j124	6077.39	3655.5	4026.47	1.663	2421.89	177794	H46054	133528	Homo sapiens clone: library of Weizmann olfactory epithelium	
3	i205	4733.41	2574.49	3989.33	1.839	2158.91	241953	H93923	6940	Soares adult brain: EST	
3	a191	1337.1	340.69	3910.8	3.925	996.41	112442	T95875	None	Homo sapiens mRNA for retroliposon	
1	e093	1295.1	325.33	3860.47	3.981	969.76	136049	R35560	None	Soares fetal liver spleen: EST	
5	e128	5881.32	3556.59	3844.26	1.654	2324.73	489404	AA045613	37012	Soares placenta: EST	
5	j033	2489.39	984.88	3802.86	2.528	1504.52	161077	H26360	None	Corticosteroid 11-beta-dehydrogenase, isozyme 1	
3	p074	1277.7	323.61	3767.08	3.948	954.1	166766	H50621	134156	Soares breast: EST	
5	h217	400.72	28.86	3718.18	9.999	371.86	545628	AA078832	108102	Soares breast: EST	
4	k132	1465.95	426.1	3577.53	3.44	1039.86	36786	R34416	21035	Cytochrome B561	
3	e107	1075.28	250.54	3539.58	4.292	824.73	78548	T60417	None	Soares infant brain: EST	
3	k162	3329.65	164.1	3426.33	2.029	1688.65	34164	R20019	None	from Stratagene liver library: similar to apolipoprotein A-1 precursor	
6	a057	351.93	31.04	3208.51	9.999	320.88	500421	AA147960	76194	Soares infant brain: EST	
6	a058	831.42	172.09	3185.36	4.831	659.33	502299	AA156840	248	Ribosomal protein S5	
5	b233	4693.32	2811.7	3140.84	1.669	1881.63	43337	H13309	21466	Proto-oncogene c-cot (protein-serine/threonine kinase)	
4	q117	2723.6	1271.45	3110.67	2.142	1452.15	345607	W72046	54886	Soares infant brain: EST; Human Aac11 mRNA, complete cds	
3	a214	923.74	213.66	3069.92	4.323	710.08	178860	H49751	None	Soares fetal heart: EST	
2	a192	5126.25	3208.52	3063.97	1.598	1917.74	28221	R13404	None	Soares adult brain: EST; 5' end is similar to MSR1 repetitive element	

a n3h

2	b205	2089.01	861.17	2978.49	2.426	1227.84	232461	H85908	None	Soares pineal gland; EST
5	a224	1394.97	447.25	2955.97	3.119	947.72	199370	R97323	85927	Tissue inhibitor of metalloproteinase 3
2	i087	2501.93	1157.32	2906.85	2.162	1344.62	324356	W47664	80706	NAD(P)H: menadiene oxidoreductase
3	c071	1332.36	420.53	2888.88	3.168	911.82	112471	T85895	1163	Proliferation-associated gene A
5	e124	840.88	190.35	2873.71	4.417	650.53	200031	R97154	None	Soares fetal liver spleen; EST
1	e098	1219	365.31	2848.71	3.337	853.69	366993	AA026304	20943	Soares fetal heart; EST
5	b236	745.1	154.8	2841.26	4.813	590.3	296664	W02194	None	Soares fetal liver spleen; EST
3	c074	1148.1	335.2	2784.28	3.425	812.9	179922	H51007	89655	Homo sapiens tyrosine phosphatase (A-2/PTP) mRNA
2	a186	915.06	226.55	2780.91	4.039	688.51	275942	R93869	66378	Soares retina; EST
1	b201	1064.65	297.27	2748.33	3.581	767.38	24608	T80490	13512	Human protein ZW10 homolog (HZW10) mRNA
3	b126	4674.26	2950.22	2731.54	1.584	1724.05	286050	N64281	48742	Morton fetal cochlea; EST
5	i162	983.41	264.12	2678.26	3.723	719.3	37720	R59435	None	Soares infant brain; EST
3	c193	4601.61	2916.89	2658.27	1.578	1684.92	148425	H12367	179499	Hemoglobin, beta
1	i087	764.02	171.17	2646.33	4.464	592.86	310622	W31182	109819	Soares senescent fibroblasts; EST
3	b171	846.52	206.41	2625.1	4.101	640.1	114411	T78159	76536	Hs mRNA for transducin-like protein; similar to guanine nucleotide binding protein
2	b146	1370.01	478.66	2551.2	2.826	891.35	278269	N94916	118779	60S ribosomal protein L24
2	m184	824.37	201.38	2550.24	4.094	622.99	172893	T20448	31748	Hs mRNA for TRE5
2	a212	983.36	7814.74	2540.05	1.258	2018.62	28225	R13406	None	Soares infant brain; EST
1	g037	869.37	222.08	2533.81	3.915	647.28	308013	W24494	19399	Soares fetal lung; EST
6	j188	5578.44	3851.84	2500.54	1.448	1726.59	22478	T74342	None	Soares infant brain; EST
2	g156	1349.09	476.61	2469.62	2.831	872.48	274375	H49806	35750	Human chromosome 16 BAC clone CIT987SK-A-962B4
1	i088	1230.4	419.22	2380.86	2.935	811.19	382989	AA084560	76152	Decorin; similar to bone proteoglycan II precursor
6	a056	559.62	106.62	2377.64	5.249	453	299666	W05763	77208	Soares fetal lung; EST
3	d161	4818.76	3053.64	2367.33	1.513	1665.13	114526	T86234	None	Soares fetal liver spleen; EST
3	c061	575.21	112.59	2363.34	5.109	462.62	113547	T79234	None	Soares fetal liver spleen; EST
3	a195	1148.21	390.65	2226.64	2.939	757.56	233826	H64619	138557	Soares fetal liver spleen; EST
3	p077	768.87	197.47	2224.76	3.894	571.4	324213	W47502	76847	Human mRNA for KIAA0088 gene
4	k131	7404.01	5699.52	2214.23	1.299	1704.49	116431	T91423	16804	Soares fetal liver spleen; EST
5	c124	2689.03	1513.31	2089.15	1.777	1175.72	199641	R96571	33433	Soares fetal liver spleen; EST
3	a064	570.23	122.91	2075.13	4.639	447.31	180285	R65333	None	Similar to cytochrom C oxidase polypeptide IV precursor
3	d187	1400.26	568.43	2049.1	2.463	831.83	328947	W45482	30825	Pancreatic islet hs cDNA clone; EST
2	i076	1040.39	354.13	2016.18	2.938	686.27	274408	H49897	93814	Soares fetal liver spleen; EST
6	m243	9144.65	7517.06	1979.98	1.217	1627.58	47171	H10763	21448	Soares infant brain; EST
5	k175	738.48	201.02	1974.49	3.674	537.46	251637	H96724	81988	Human mitogen-responsive phosphoprotein (DOC-2) mRNA
3	c096	1998.95	1008.36	1963.7	1.982	990.58	279481	N45602	None	Soares multiple sclerosis; EST
5	i034	3385.63	2153.51	1937.07	1.572	1232.12	201839	R99977	108048	Soares fetal liver spleen; EST; weakly similar to line-1 protein ORF2 (Hs)
2	o135	2000.18	1022.05	1914.2	1.957	978.12	223092	H66650	33687	Soares retina; EST; contains LTR5 repetitive element; similar to Alu repetitive element
2	m232	2028.18	1044.69	1909.35	1.941	983.48	31546	R20842	23075	Soares infant brain; EST; similar to Alu repetitive element
1	p037	1521.81	676.29	1902.59	2.25	845.51	321259	W55913	76317	Ribosomal protein L31
5	b237	386.83	59.86	1880.87	6.127	306.96	531514	AA074032	83848	Triosephosphate isomerase 1
3	a216	623.41	155.24	1880.14	4.016	468.18	279374	N45540	138692	Soares multiple sclerosis; EST; similar to retrovirus-related envelope protein
6	i246	1661.35	779.4	1879.94	2.132	881.95	306904	W21392	None	Soares fetal lung; EST; contains Alu repetitive element

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AMD and ocular drusen ^{have} increased levels of specific ^{autoantibodies} autoantibodies when compared to controls without drusen. Particular attention will be paid to a potential relationship with AMD phenotypes, drusen status, and the "stage" of the disease. The identification of autoantibodies or mediators of chronic inflammation may serve as a means for the development of diagnostic assays for the identification of AMD.

Study Design: Visual acuity measurements, stereo macula photos, and peripheral photos will be taken at the beginning of the study and every six months thereafter. Blood and sera will be drawn when subjects enter the study and every 6-12 months thereafter. DNA will be prepared from a portion of each blood sample for future genetic studies. The presence of serum autoantibodies and immune complexes will be determined using standard protocols. In addition, sera will be reacted with tissue sections derived from donors with and without AMD, followed by a secondary antibody that has been adsorbed against human immunoglobulins. Western blots of retina/RPE/choroid from AMD and non-AMD donors will also be incubated with serum samples to identify specific bands against which autoantibodies react.

In addition, levels of the following proteins, additional indicators of autoantibody responses, chronic inflammation and/or acute phase responses, will be assayed by a clinical diagnostic laboratory. These will include Bence Jones protein, serum amyloid A, M components, C-reactive protein, mannan binding protein, serum amyloid A, C3a, C5a, other complement proteins, coagulation proteins, fibrinogen, vitronectin, CD25, interleukin 1, interleukin 6, and apolipoprotein E. Serum protein electrophoresis, lymphocyte transformation, sedimentation rate, and spontaneous, whole blood, white cell count will also be measured.

The presence of antibodies directed against the following proteins (many observed in other age-related conditions and/or MPGN) will also be determined: type IV collagen, glomerular basement membrane, neutrophils, cytoplasm (c-ANCA, p-ANCA), C3 convertase (C3 nephritic factor), alpha-1 anti-trypsin levels (decreased in MPGN), epsilon 4 allele, apolipoprotein E, GFAP, ANA, serum senescent cell antigen, S-100, type 2 plasminogen activator, alpha-1-antichymotrypsin, SP-40,40, endothelial cell, parietal cell, mitochondria, Jo-1, islet cell, inner ear antigen, epidermolysis Bullosa Acquisita, endomysial IgA, cancer antigen 15-3, phospholipid, neuronal nucleus, cardiolipin, and ganglioside.

Table 6 Serological Tests for Immune-Mediated Processes

Autoimmune and Chronic Inflammation

Cells:

Whole blood cell count, hemogram plus differential

CBC, hemogram.

5 **Immunoglobulins:**

Imunoglobulin A,G,M,D,E quatification

IgG subclass quantification

Kappa/lambda light chains- quantification and ratios

10

Miscellaneous Proteins:

Serum protein electrophoresis

Complement , total classical and alternative

15 Compement: C3, C4, C5 quantitative

Bence Jones proteins

M component

C reactive protein

20 Serum amyloid A

Coagulation proteins

Fibrinogen (and/or ESR)

Elastase inhibitors

Elastin and collagen peptide fragments

25 Serum beta-2-microglobulin

Serum carotene

Creatine kinase

Rheumatoid factor

C-reactive protein

5

Immunocompetent cells:

Lymphocyte immunophenotyping and absolute CD4 cell count.

Anti-OKT3, IgG antibodies.

CD34 Stem cell count.

10

CD3 cell count.

CD4 cell count.

Lymphocyte mitogen and antigen profile screen (LPA).

Lymphocyte antibody screen???

NK cells.

15

T and B-cell markers. (which ones they screen?).

CD4/CD8 - absolute count and ratio.

HLA phenotyping, both class I and II. HLAB-27.

Cytokines:

20

Interleukins

Fibroblast growth factor

Vasoactive intestinal peptide (VIP)

Autoantibodies:

25

Anti-nuclear antibody (ANA)

Anti-neutrophil cytoplasmic antibody (ANCA)

Double stranded DNA antibody

Anti-ribonuclear protein antibody

Scl-70 antibody

5 SM antibody

SS-A antibody (anti-RO) and SS-B (anti-LA) antibody

Anti-neuronal nuclear antibodies

Antineuronal nuclear antibody (Purkinje cells).

Jo-1 antibody

10 Paraneoplastic antibody A

Anti-cardiolipin antibody

Anti-glomerular basement membrane antibodies

Mitochondrial antibody

15 Anti-ganglioside assay

Anti-Streptolysin-O screen

Anti-sulfatide antibody

Anti-Thyrocellular antibody

Antibody to inner ear antigen

20 Bullos pemphigoid antibodies

PM-1 antibody

Adrenal cortical antibody.

Liver-kidney microsomal antibody

Mitochondrial antibody

25 Parathyroid antibody

Parietal cell antibody

Pemphigus antibodies

Smooth muscle antibodies and striated muscle antibodies.

Islet cell antibodies

5 Lupus anticoagulant

Anti-viral and anti-bacterial antibodies:

CMV antibody

Group B strep antigen

10 Hepatitis B, E, C, A antibodies

Helicobacter Pylori antibodies

Antibodies to CMV, EB virus, Herpes Simplex, Measles, mycoplasma, Rubella,
Varicella-Zoster

15 **Others:**

Cancer antigen 125

Cancer antigen 15-3

Carcinoembryonic antigen

20 Small fiber axonal profile

CNS serology battery

Sensorimotor neuropathy profile